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The Problem of the Mild Psychoneurotic in the Army

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The men in the armed forces represent a cross section of our population and are the product of various hereditary and environmental conditions. In the Army they must conform to a way of life that carries with it regimentation, fatigue, discomfort and hazard to life. A strong emotional drive acting within and without as exemplified by group loyalty and patriotism or an intelligent sympathetic consideration of their problem by medical officers may aid them in making an adjustment. In general, they are not soldier material and can serve more effectively in civil life since under strain they develop multiple functional complaints that destroy their usefulness as soldiers.

■ IN considering the problem of the mild psychoneurotic, it might be well to point out that the term "mild" does not refer to the degree of severity of the manifestations in these cases but rather to their relative stability and the weight of the load that is required to upset their equilibrium.

The men that make up an army brought together as ours has been, by drawing on our total manpower in certain age groups, represent a cross section of our population—the strong and the weak, the industrious and the indolent, the skilled and the unskilled, the courageous and the cowardly, the stable and the unstable. They are the product of their heritage and their environment. They are idealistic, self-seeking, patriotic, indifferent, group conscious and egocentric, according to their social, moral, or religious background. They come from the shops, the farms, the slums and the universities. They have the outlook, prejudices and traditions of numerous races and creeds and of various political philosophies. In the army they must adjust to a general pattern. They must sink their personalities in the unit they serve. The course of their life is suddenly altered. Separated from the security of their home and familiar social environment, they must create a new life under strange conditions. Freedom of action is lost. No longer are excuses for delinquencies listened to by sympathetic ears. Even their identity is submerged and their serial numbers become more important than their names.

It is obvious that much of this material is not the stuff from which soldiers are made. The physically unfit must be excluded and, with even greater care must those with unstable personalities be weeded out. The local boards and induction boards have screened out thousands of these individuals but other thousands have slipped through the net and now present one of the major problems of the army. Thousands of them are

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being discharged and now or later will be a problem of civil life. For the most part they are not the product of army life or combat service. They were basically unfit when they entered the army and totally unable, due to personality defects, to adjust to army life or meet the strains inherent in the performance of the duties of a soldier. We are particularly concerned today with the milder group since this group is less often recognized in civil life and often in the protected and narrow groove in which they live encounter no serious difficulty and, if returned to their former environment, may adjust themselves again. On what basis are we to judge these individuals, how are they to be handled in the army and what is to be their fate afterwards?

There are two classes of mental disorders. There are those due directly to organic lesions and those which have no demonstrable structural change. Psychoneurosis falls in the functional group. It is a non-volitional combination of clinical symptoms based on anxiety, fear, compulsion, obsession and conversion phenomenon. In war this syndrome is largely a defense mechanism resulting from a desire to preserve one's life, security or social habits and, at the same time, lose nothing of the regard or respect of one's fellows. It is essentially an alibi mechanism. It is believed that this is accomplished through the operation of the subconscious mind although at times it is difficult to separate the conscious and willful malingerer from the true psychoneurotic, in fact, some believe there is no line of demarcation. Its name implies both psychological and physiological components and the disorder is reflected in both psychological and physiological symptoms. It differs from the graver psychological disorders, Dementia Praecox and Manic Depressive Psychosis in that it is only a partial reaction and disrupts only a portion of the functions of the mind, the personality is less disturbed, the emotions remain relatively pliable and insight and judgment are better retained. One suffering from psychoneurosis is able to make an objective examination of himself and evaluate his disorder, although he may not be able to do anything about it.

As their emotional feelings and instinctual drives tend to express themselves they encounter the criticism of the outside world, morals and conscience and the channelizing forces of environment. They do not care to undergo modification or change their direction. These urges are primitive and crude, know no laws, no logic or values, no good or evil, no morals. The pleasure principle reigns supreme. They cannot be destroyed any more than physical matter can be destroyed. If they are strong, as are the instincts of self-preservation in time of war, and moral obligations and draft boards rush them to the battlefront, the impact results in conflict and complexes to be fought out in the subconscious mind. The processes of disguising, compromising or resolving these difficulties are spoken of as mental mechanisms. They are clever but they are weak. The turmoil created by this conflict is the disease itself. Our reactions to these various impasses or divergent tendencies, how we feel about them, what we think about them and what we do about them, expressed in words or conduct through motor or sensory means, in symbolic form or tension states, are the symptoms per se of the psychoneuroses. They are often so disguised and dramatized as to fascinate the patient himself and arouse the sympathy of others. In a well-balanced person these driving forces are surrounded by protective forces and he is able to resolve, repress or effect a compromise, whereas in the psychoneurotic these conflicts are resolved by conversion into functional symptoms which he believes will allow him to follow his basic impulses and yet escape the consequences.

It is the belief of the psychiatrist that probably eighty per cent of all psychopathological disorders developing in adults are based on the persistence of the immature emotional reactions of childhood. The doting parent who fondly hopes to prepare a child for life by affording it protection against all childhood stresses and strains is only fostering a weakling incapable in later years of meeting the responsibilities of adult life. The precept of the ancient Medes that boys should be taught to ride, to shoot and to tell the truth, has much to commend it. The following case will illustrate this point:

Private W. C. D. was admitted to Percy Jones General Hospital March 29, 1943, with an anxiety type of neurosis. He told of adjusting very well in the army until he witnessed his buddy in the same fox-hole being blown to bits and of watching the wounded suffering for hours before they died. In talking with his

mother, she became upset and cried and presented photographs of her boy from babyhood through his senior year in college, depicting him as a serene young man and relating how she had always tried to protect him and taught him never to smoke or drink. She said he had occasionally gone to church with a girl in a group but never alone and that he had never been permitted to take extracurricular work in school because she was afraid he would overexert himself. His teacher wrote that she felt sorry for him because his mother would come and sit in school with him and not permit him to engage in strenuous games or play on the slide at recess for fear he would get his pants dirty. At first he was very idealistic and spoke of wishing to continue in service but after his mother's visit his condition became aggravated and it was necessary to disposition him on a Certificate of Disability.

This soldier was not only tied to his mother's apron strings but psychologically certain fetal anatomical ties had not been severed. There is no straight road over which parents may guide their children; rather, it is a steep and twisted trail which the child must learn to climb. There are certain maps and guideposts and the child's feet can be set in the path but it must do the climbing.

In contrast to this patient, we have the case of C. C. who was admitted from the same convoy, with the same diagnosis and whose trouble was precipitated by similar experiences. In developing his history it was learned that he came from a family of hardy landowners in a neighboring state. The father was energetic, thrifty, strict but kindhearted. He was proud of his several sons. He hunted and fished with them and treated them as pals. In talking with him he said, in his usual way of expressing himself, "By gosh, I tell you there ain't none of my kids that's going crazy because there ain't no crazy people in Ma's family and there ain't none in mine.' After seven days in the hospital and thirty days' furlough, this soldier was returned to duty, soon became a sergeant and our last word was that he was headed for Officer Candidate School.

How frequently do we encounter these cases in the army. In the United States they are entering the hospitals at the rate of twenty-seven per thousand per year. Mental failures are second only to battle wounds and malaria as a cause of hospitalization in combat areas. Between fifteen to twenty per cent of all casualties returning to the United States are neuropsychiatric cases and in certain theaters of war this figure has been as high as forty per cent. It is only fair to say that relatively few of these are battle reactions. Most of them should never have reached the zone of operations and many of them were hospitalized soon after debarking. There have been very few wounded psychoneurotics. This is susceptible of two explanations, namely: First, few psychoneurotics actually go into combat; second, a disabling wound may cure the psychoneurotic manifestations, since it offers the perfect crutch.

Of the total admissions to Percy Jones General Hospital, fifteen per cent are sent directly to the neuropsychiatric section and an additional twelve per cent are seen in consultation. Most of these are disposed of on a psychiatric diagnosis. These figures do not include neurosyphilis or neurological cases, or a considerable number of functional cases seen and disposed of on the gastrointestinal and cardio-vascular services.

What can be done about this matter? Fundamentally we should go back thirty years and raise a generation less coddled, less spoiled and less spoonfed, and with a greater sense of group reponsibility.

The examining boards have come in for more than their share of criticism, since the screening out process is not as easy as it appears on the surface. A few questions and a short objective examination is inadequate to determine who will make a good soldier and who will not. The severe and moderately severe cases should be easy to exclude but in civilian life the mild psychoneurotic has a greater leeway in protecting himself and may be able to carry on fairly well. If his load is too heavy he may take a day off or change jobs. He is not able to do this in the army but must become an efficient unit in his organization or be discarded. You may know him as a fairly intelligent individual who makes the rounds of the doctors' offices, with multiple vague complaints, and frequently resorts to quacks. He is overanxious, rigid, opinionated and overconcerned about his health. He is lacking in humor, often overserious, not given to sports and subject to mood swings.

Anyone who has shown neurotic traits, such as bedwetting, nail biting, night terrors or sleep walking and those who are morbidly anxious, excitable, arrogant or who show signs and symptoms of anxiety or fear, or afflicted with obsessional ideas, compulsion acts or symptoms of systemic diseases of undetermined origin, should

be immediately rejected as unsuited for the military service.

There is no place in the army for the mental defective unable to plan, calculate or construct, awkward and untidy in personal habits, who learns by precept rather than concept and is incapable of comprehending and executing complex orders. There is no place for the psychopathic individual who proceeds without definite pattern or standardized activity, who does not respond to social standards of decency or honesty. There is no place for the inebriate or the drug addict. Those individuals who find it difficult to adjust in civilian life with many avenues of escape will find it almost impossible to adjust to the routine, restrictions and regimentation of military life. They may even disrupt discipline and morale and retard progressive military training. When inducted, such a soldier sooner or later finds himself a dud in his job. The result is tragic. He is unable to pull the blinds against the exacting orders of a demanding sergeant or the critical scrutiny of his fellow soldiers. He reposes in moments of inertia but he does not sleep. Light noises strike terror into his heart and his stomach. He sits on the edge of his chair. His existence is one of jumpiness and apprehension. He is afraid to turn a corner for fear of meeting himself. On maneuvers be becomes more concerned with the cramp and pain in his rear axles and what happens to his digestion than what goes on in the army or the universe. He becomes afraid his heart will not beat or he will cease breathing and keeps a camphor bottle by his bedside.

Their patriotism may be sterling but their usefulness is negative. They are far better able to contribute at home on the farm or in defense plants. Their induction is unfair to them. They wait in line to report on sick call, many the first day after entering the service, in the hope that the army doctor will be able to help them. They occupy our hospital beds, urgently needed by others. Many from our Service Command have been in the hospital three out of four months of service, while many from overseas have been in the hospital eleven out of fourteen months of service. They become a heavy financial load and they render no useful military service. There is no place in our ships to transport them overseas and back again.

Many who succeed in civil life will fail in military life. They are unable to turn to their favorite book that makes a successful appeal to the apathy. They cannot indulge in luxuries or give vent to their prejudices. They cannot be running back from the Solomons or Guadalcanal to consult their favorite physician. They cannot stop in the drugstore for a soda or go to their club for a highball and they cannot go fishing. They are not able to secure advice from their parents or their friends who may lighten their burden by the balm of sympathy. They must endure the clouds of their special discomfiture which follows them like a pup and there is no escape from this sudden, unplanned turn in their lives.

Strange people knock on the entrance gates to the army. People with queer skills, and odder personalities—acrobats from the circus, hardy youths from the mills and farms, people just young, flush with money, heady, rebellious, self-indulgent and with a temperament and a sense that "war is a moral outrage." Some exhibit brazenness rather than breeding, glibness rather than wisdom, audacity rather than forbearance. The army is scarcely an organization conducive to psychological serenity or efficient digestion. The business is hazardous and insecurities of the quivering youth who enters its gates are apt to be intensified.

The soldier must be looked upon as a type of individual requiring creative qualifications, men able to respond in an honest, truthful, decent and adult manner to his fellow associates, men able to think clearly and logically and have a tenacity of purpose, men who will conform to organized authority and cultivate responsiveness and obedience to others.

Many directives stress the fact that the "army is waging an offensive type of warfare and is not to be considered a social service or curative agency, a haven of rest for the weary, a reform school for the delinquent, a gymnasium for the weakling or a psychiatric clinic for the emotionally unstable."

Once a soldier is inducted, much responsibility rests upon the army and especially upon his immediate commanding officers. He may be made into a well trained, well disciplined and qualified soldier, contributing much to army morale and determining its success. Of greater

importance than mere numbers of men or the materials of war is their proper selection and intelligent handling. The new recruit is confused and disturbed, he has entered a strange environment away from the security of his home. He is deprived of his freedom of action and subjected to discipline but does not yet know his privileges or the careful thought that has been given to protecting him. He has lost his privacy and is thrown into mess and barracks with rude men where he hears alarming stories of the life of the new recruit. This is a difficult period of adjustment and much future trouble can be avoided by thoughtful handling of the soldier at this point. Attention should be given to his individual needs, assistance with his insurance and allotment, maintenance of communication with his family, passes, entertainment and the assurance of care of sick relatives at home. The officer who looks after his men will gain their respect, confidence and loyalty and will be rewarded by a high morale in his organization.

In seasoned troops the factors are more positive: waiting, boredom, suspense, physical strain, worries about home affairs, loss of sleep, irregular and inadequate meals and debilitating diseases, such as diarrhea or malaria.

In the actual combat zone the causes are fear of bodily danger, constant alerts, bombardments and the sight of panic and death. Fighting in small detachments, as frequently occurs in jungle warfare, the mental hazard is much greater than when masses of troops are deployed. Where small groups are cut off, frequently only a few will escape and the effect of their experience on these few may be disastrous. Man possesses a strong social nature—the herd instinct. His confidence is impaired when alone. Many soldiers returning from the Southwest Pacific will tell you that while waiting in fox-holes, if there are others about them in speaking or whispering distance, they are relatively comfortable. They not only feel more secure from danger of surprise but also from what is called "separation anxiety."

The majority of patients entering the hospital originating in the home area show conversion phenomena, neurasthenia or hypochondriasis, while those from the battle areas exhibit anxiety states and fixation phenomena referable to the gastro-intestinal tract, respiratory, cardiac or urinary systems. Their complaints vary widely with the many clinical symptoms arising. The immediate and predominant reaction from the battlefield is confusion, panic, terror, rage or a stupor-like trance state with loss of the instinct of self-preservation and volitional control. In many soldiers these terror states are short lived and there is amnesia for their experience and the soldier may continue on with his work. Certain of the soldiers that break under extraordinary strain make good progress toward recovery on returning to this country.

Later there is a gradual development of symptoms not unlike those encountered in peacetime. They may be expressed in symbolic form, paralyses, tics, hysterical blindness, aphonia or amnesia. They may be shown in nervous tension, emotional and mood states, fear, apprehension, anxiety, sudden attacks of intense restlessness, insomnia, nightmares, startle reactions, bouts of depression and thinking disturbances. They may be shown in character changes, irritability, sullenness, resentfulness and display of temper and, finally, they may be manifested by vasomotor or autonomic nervous system syndromes—headaches, faintness, dizziness, weakness, easy fatigability, sweating, cold hands and feet, palpitation of the heart, shortness of breath, jerky, jittery feelings, frequency of urination, nausea, vomiting and diarrhea.

In most instances we believe that soldiers exhibiting evidence of psychoneurosis, however mild, should be returned to civil life. In general they will do better if returned to the familiar environments of their homes. While no stigmata or disgrace should be attached to the soldier who has put forth his best effort, we are still confronted by the fact that in many instances the lack of will power to perform an undesirable or distasteful duty is the background of his failure. Before these men are discharged, each case is carefully considered by a board of medical officers who have studied all aspects of his particular case carefully. Among the other duties of this board is the fixing of the line of duty. In simple parlance, this means the determination of whether or not the government is or is not responsible for his condition. If he has become mentally disabled by reason of unusual strain and hazard of the service, then he is a responsibility of the government, otherwise he is entitled

to no special compensation, now or later, by reason of his military service. It has been a common observation that the soldiers returning from furlough are definitely worse upon their return. We strongly suspect that they have been subjected to an excessive dose of sympathy and possibly have been enticed by the allurements of the easy life and high pay of civilian employment. We suspect that they have been encouraged to believe or to feel that they have already performed their full duty and that they should leave the further prosecution of the war to others. A higher morale at home with a courageous facing of the sacrifices necessary to preserve our heritage and an adjournment of expression of maudlin sentiment will help to preserve these men and help to win the war.

MSMS

Postpartum Sterilization

A Generally Indefensible Procedure

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Postpartum sterilization may be defined as the surgical occlusion of the Fallopian tubes without any indication for laparotomy other than the attainment of sterilization. The operation has been rapidly extended in the last few years and is now utilized in a series of medical conditions as well as for sociological states. It is contended that the procedure is completely safe and obviates the dangers of future childbirth. This paper maintains that many medical conditions for which sterilization is performed will improve spontaneously or as a result of treatment, and that the woman may subsequently desire children. It is felt that social conditions are the function of society as well and not of the doctor alone. Reasons are given why postpartum sterilization should be restricted to a very small group of cases.

■ Postpartum sterilization may be defined as the surgical occlusion of the Fallopian tube lumen by means of an intraperitoneal operation performed shortly after parturition—usually in from 24 to 48 hours, and with no existing indication for laparotomy other than the intent to prevent future conception.

The operation had been performed for some years without attracting much attention until the paper of Adair and Brown in 1939 caught the interest of the profession and in the last four years it has grown greatly in popularity.

Curiously enough the paper of Adair and Brown was not at all an appeal for the extension of postpartum sterilization, but simply advocated the performance of the operation within 24 hours after delivery, and compared this practice favorably with the performance of Cesarean section without other indications than the opportunity to sterilize the patient.

The fifty cases reported in this paper were all instances of chronic disease in which subsequent pregnancy was deemed unwise.

In many clinics puerperal sterilizations are now being done for a variety of reasons both medical and sociological.

The medical indications are usually heart diseases of some variety; hypertensive vascular disease with or without involvement of the heart; chronic nephritis; pulmonary tuberculosis; diabetes, thyrotoxicosis, and many varieties of neurologic disease. To these are often added early senescence of the patient, pendulous abdomen and excessive dental pathology, all thought to be due to multiparity with poor social and personal hygiene.

In another group of patients, inability to use contraceptives successfully or the noncoöperation of the husband leads to a request, too often acceded to, for sterilization after the third or fourth normal pregnancy.

The major medical indications for sterilization would seem, at first glance, to be not only proper but wise preventive medicine, the operation tending to prolong the life of the woman and spare her the dangers of future childbearing but even here, a little reflection will show that radical procedures may be vastly overdone. In the matter of pulmonary tuberculosis for example, the woman who at twenty-one years of age may present marked evidences of an active infection, may be completely cured at twenty-five and eagerly desire a child. The modern treatment of tuberculosis with its rest, lung collapse and the like, very often reduces this infection to a purely temporary disease with complete restoration to normal within a comparatively short time. Every physician of experience has known women, who, sterilized after their first pregnancy, are rendered morbid and unhappy because of their inability to procreate after their return to health.

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It is common knowledge that contraceptive devices and methods have been developed so well that their efficiency is very high when they are used intelligently and most women can now prevent conception for an indefinite period. Furthermore, should such a patient become pregnant through a failure of contraception, before she is in condition to go through with a pregnancy, early termination of the pregnancy is a simple procedure and if sterilization is then indicated, abdominal hysterotomy and tubal ligation under local anesthesia is in no wise more serious a procedure than postpartum obliteration of the tubal lumen.

It is certainly conservative to say that one-half the women concerned are able to control conception by preventive measures, and if this is true then 50 per cent of postpartum sterilizations are unnecessary.

Precisely the same holds true in cases of heart disease and in many other medical conditions in which improvement may reasonably be expected to occur as time goes on. There are a few medical lesions, however, in which the above does not hold true. Well-defined hypertensive vascular disease and established nephritis do not often permit of improvement, and here one cannot object to postpartum sterilization. This is true also of active types of permanent involvement of the nervous system and almost always so in the presence of serious mental defect. The writer's objections to postpartum sterilization do not extend to the termination of the reproductive ability of idiots or insane women.

It is true that, as has been argued, sterilization is one of the safest operations in surgery and that the risks are practically nil. This is the case, but any surgical invasion of the peritoneal cavity carries with it a definite though very small mortality and morbidity. Peritonitis of unknown origin is always a possibility and postoperative embolism, adhesion formation and other complications of abdominal surgery are constant possibilities.

The danger of the operation is not considered as an important contraindication, except that the writer decries any unnecessary surgery, no matter how safe it may be.

One may summarize, then, the medical indications for postpartum sterilization as being the existence in a woman of one or more of a small group of disease entities which experience has shown offer little or no probability of improvement no matter how they be treated. To this small group may be added the rather larger one of those patients suffering from mental deficiency or real insanity of a transmittable nature.

The great majority of medical conditions now invoked as a reason for this operation are susceptible of cure or marked amelioration as time goes on and women suffering from these more or less temporary disabilities are better treated by well planned contraceptive measures, with the resulting possibility of future child-bearing should the occasion arise, than by permanent sterilization.

It is with the sociological aspect of this matter that the writer is chiefly concerned. There is a growing tendency in a number of clinics for the obstetrician or the social worker to confer with patients who have borne a number of children, sometimes with short intervals between pregnancies as to the advisability of the definite prevention of future conceptions. The most pernicious feature of this practice is the ease with which a woman, at the end of a debilitating pregnancy or just after she has completed the effort of labor, may be persuaded to forego similar experiences henceforth. The same woman who eagerly accepts sterilization 24 hours after delivery, may bitterly repent her decision after a year has passed.

This brings up the whole question of what constitutes a proper number of children, the advantages and disadvantages of rapidly repeated pregnancies not only with regard to the health of the mother but the standards of living in which the children are reared.

There is very little factual knowledge as to the deleterious effects of frequent childbearing upon women. As to the children, statistics are also quite variable. Gruber finds that "the third and fourth child of the same woman are the strongest and that, beginning with the fifth, sometimes with the fourth, their vitality diminishes pretty rapidly. The unfavorable influence is especially great, where pregnancies follow each other within one year. Westergaard has worked out that out of 100 children who were born within one year after a brother or sister, 19.9 died before they reached their fifth year; but out of 100 who were younger by more than two years,

only 11.8 died. Even those children who were born between one and two years after their predecessors showed a fairly higher mortality than children who followed after a longer interval. Pregnancies should not, therefore, succeed one another more rapidly than at intervals of two and one-half years."

Unfortunately, these figures deal only with the mere fact that definite numbers of infants perished, under varying intervals of pregnancy. They do not state whether the deaths were due to malnutrition from improper feeding, poor hygiene or indeed, any cause. It may well be that the discrepancies may be due to social maladjustments rather than biological defects.

As against this one may call attention to the many persons of great mental and physical vigor who were the youngest of very large families. Benjamin Franklin is one of the most notable examples.

However, this communication deals with the effect of multiple childbearing on the woman, not the offspring, and here the lack of definite knowledge is always evident.

Every doctor knows the woman who is prematurely aged at forty. With teeth destroyed by caries, a pendulous abdomen and very likely a beginning procedentia, and who presents a living example of the debility attending frequent pregnancy and labor.

In strong contrast is the youthful matron of equal age, who has borne an equal number of children and who enjoys excellent health and in whom senescence has apparently been not advanced but delayed, by the events of reproduction.

This whole subject is so complex, there are so many intextricably entwined factors, of nutrition, environment, community sanitation, housing and the like, that to single out the mere fact of multiparity as the causative agent has no validity.

It might be possible to amass data in which the effect of large families to maternal health could be portrayed in relation to the social status of the mothers, the grade of medical care they received during pregnancy, labor and the puerperium, the effect of housing and nutritional variation and so on. This would be an enormous task, but would well repay the doing. The subject is an immense one presenting definite medical aspects, it is true, but it is much more closely linked to economic, social and community problems and underlying all, the rights of individuals and families to live life as they choose.

When the doctor steps into this intricate maze of complicating elements and with scalpel and ligature puts an unalterable end to a woman's reproductive life, he ignores all the other phases of sociology and says in effect, "In my opinion this woman has borne more children than may be reared by her and her husband in what, in my opinion, is a minimum standard of child life, health and education. I therefore decree, that with her consent, this woman shall never, under any circumstances, bear another child."

It may be argued with some truth, that the doctor does and should play an important part in matters of community and personal welfare and that he does in close connection with governmental agencies, supervise the premarital health of individuals, including the right to forbid marriage when either partner is found suffering from venereal disease in transmissable form.

He does originate and with the social worker, direct bureaus of marriage counsel, spacing of children, prevention of the spread of contagious disease and many like phases of sociological activity.

It will be observed that in all of the above matters the position of the medical profession is one of advice and education and not of actual interference.

Take so simple a question as that of vaccination against smallpox. Physicians have long recognized the necessity for universal vaccination and have secured in most of our States legislation rendering this safeguard compulsory among all children attending public schools, and among all citizens when an epidemic threatens. The doctor, however, has no right to insist upon vaccination of any individual unless he is so supported by the laws enacted by Society as a whole and under which laws he proceeds.

The late Gilbert Chesterton once wrote a charming essay called Topsy Turvy Land in which he deftly satirized many of the absurdities which exist in our civilization. He uses as one of his texts a newspaper debate as to whether a bank clerk on a salary of 30 shillings per week should marry. This says Chesterton, is pure evidence of upside down thinking. The real point is should

a healthy and vigorous young man be prevented from living a complete life and producing children because Society denies him sufficient money with which to do so.

Applying the same logic to the question under discussion, the question may be posed as to whether it is not the duty of the State to see to it that a fertile married couple may produce as many future citizens and workers as they are capable of doing with the assurance that proper environment and nutrition is available to them.

The crux of this whole matter is the extent of the power of the physician in regulating family life in so far as reproduction is concerned. Where do his prerogatives and duties end and how far should he assume authority in performing acts which are irrevocable and whose consequences may be far reaching, and which intrude upon the definite duties of organized society as a whole.

It may be argued that all this is a great pother about a small matter, that postpartum sterilizations are always performed with the consent of the patient and frequently at her urgent request and that they serve to aid communities in the regulation of possibly unwise pregnancies and indeed to anticipate the social progress in which the community shows a definite lag.

A fairly parallel instance may be cited as regards the delivery of children by Cesarean Section as against the vaginal route.

In quite a few sections of the country there arose a few years ago, a tremendous vogue for abdominal hysterotomy as a method of childbirth regardless of indications. Women told each other of the ease of this system, babies to be delivered by elective section at a time convenient for mother and accoucher, and without any of the pains and anxieties of labor. It was also pointed out that abdominal delivery dispelled the dangers of birth injuries to the child and was, on the whole, somewhat safer for the infant.

Even though the patients advocated and, indeed, demanded delivery by Cesarean section, the obstetric profession opposed the practice vigorously and today in estimating the quality of work done in various clinics, the relative number of sections performed is always under close scrutiny. Institutions and obstetricians presenting too large a ratio of abdominal deliveries are continually on the defensive to explain these unnecessary operations.

This seems to be precisely the status of postpartum sterilization performed without important and definite medical indications.

There are certain pschycological sequelæ of sterilization, the effect of which upon family life has perhaps been underestimated or at least has not been freely discussed when this question is under consideration. Sometimes when a woman has been sterilized upon a merely social or a feeble medical indication, it happens that the husband either dies or divorce takes place. Presently the woman remarries and finding herself happily situated, with her new husband desires children often at his insistence. Knowledge that she is irrevocably barren may bring bitter heart searchings and a serious questioning as to the correctness of the medical advice in consequence of which the sterilization was allowed.

In other instances calamity overtakes the family. In one such case with which I am familiar, the five children of the couple were instantly killed in an automobile accident.

The mother had been sterilized shortly before upon the ground that contraceptive measures had proven unsuccessful and that the woman had borne as many children as she could properly rear.

The grief of this family when they realized that under no circumstances could another child be borne to them was profound and resulted in serious psychic deterioration of the mother.

There is another rather unpleasant aspect of the effect of sterilization of women, for whatever cause, upon conjugal relationship. Although tubal ligation has no effect whatever upon sex characteristics it is often difficult even for an intelligent layman to appreciate this fact fully and any decrease in the libido of his partner sometimes cause a suspicion which as time goes on becomes a settled conviction that the operation must be responsible in some way. The usual end result needs no further discussion.

Again, the woman herself may be a person of somewhat unstable moral fibre, possessing withal a vigorous sex consciousness. Realizing that the danger of conception is no longer a valid deterrent, extramarital relations all too often break up the family life.

Sterilization after Cesarean section, while not strictly germane to the subject under discussion, still merits consideration here. It would seem that no woman should be placed in peril of her

life more than once and although the same rules hold good as were suggested in planning sterilization upon medical indications, still in the case of the Cesarean section of the abdomen is already opened and here the patient herself, should be the judge as to whether she is to run the risk of a second section. This is particularly true since no operation is involved other than that already in progress for the delivery of the child.

The purpose of this paper is to comment upon some of the evils which may so readily follow upon postpartum sterilization. It has been shown by simple logic that a large number of such sterilizations are unnecessary even though done upon a legitimate medical indication. It has been argued that the physician is often tempted to assume a somewhat godlike pose as regards advice to women who in his opinion (and in theirs) have failed to regulate their procreative faculties with discretion and in accord with their spiritual and material opportunities to enjoy a satisfactory life.

Some of the more remote psychic maladjustments which may follow have been considered, and one has attempted to point out that the failure of society as a whole to attend to matters involving the life, security and happiness of the people comprising such society, cannot often be corrected by medical or surgical intervention alone.

To aid in the education of Society regarding social problems is the important contribution of the medical profession rather than the attempt to dispose of these problems by radical measures.

The title of the paper is harsh, the arguments involve usually only the negative side of the subject and the virtues of postpartum sterilization have been largely ignored.

This has been done deliberately in order to marshall the objections to the procedure in concise form and to invite the profession to scrutinize the whole large matter closely and objectively in order to prevent a plausible and simple attempt to solve a world-old problem from gaining too much headway and from being grossly overdone.

MSMS

Modern equipment for flying at high altitudes has been developed carefully as scientific knowledge of the effects of altitude on the body increased. Plane and flyers are adjusted to the stratosphere by intricate tests and apparatus.

Edema in Children

Causes and Treatment

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The various physiological and pathological mechanisms of edema formation are discussed briefly. The role of protein dietary deficiency and inability of the body to fabricate serum proteins are stressed. Recent advances in our knowledge concerning the etiology and treatment of nephrotic, nephritic and cardiac edema in children are likewise reviewed. Because of widespread partial starvation, the incidence of edema among children in war-torn and occupied countries is extremely great. The important relationship of this state to the general health of the child population is given special attention.

■ THE INCIDENCE of edema among children varies greatly in different parts of the world due largely to variations in the prevalence of the primary disease conditions which give rise to it. In many war-torn countries today it is the most apparent sign of serious and widespread malnutrition. If edema is defined as "retention of water in the body. tissue spaces in abnormal amounts," it is obvious that this state of superhydration occurs far more frequently than is ordinarily considered to be the case when pitting of the subcutaneous tissues on pressure is the sole criterion used for its detection. An older child may, for instance, accumulate as much as five or six pounds of edema fluid before its presence is detectable by palpation or inspection, if the distribution of water is general and the elasticity of the skin and subcutaneous tissues is not too greatly reduced.

The clinical disorders with which edema is most frequently associated in early life are the following:

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1. Malnutrition
   (a.) Inadequate protein intake
   (b.) Faulty digestion and absorption of proteins (e.g. in chronic cystic pancreatitis or in prolonged drainage from high enterostomy or in chronic diarrhea)
   (c.) Possibly inadequate intake of vitamins (particularly thiamine and ascorbic acid)
2. Certain forms of liver disease
   (a.) Idiopathic atrophy
   (b.) Severe cirrhosis
   (c.) Chronic passive congestion (e.g. in constrictive pericarditis)
3. Diseases of the kidneys
   (a.) Lipoid nephrosis
   (b.) Nephritis, particularly chronic forms
4. Cardiac decompensation from
   (a.) Rheumatic carditis
   (b.) Congenital cardiac defects
5. Anemia
   (a.) Hydrops foetalis (with congenital erythroblastic anemia)
   (b.) From repeated hemorrhages
   (c.) Following extensive burns
   (d.) Miscellaneous forms
6. Allergic and toxic states
7. Certain disturbances of endocrine function

In spite of obvious dissimilarities between the primary clinical disorders represented in this list, the underlying physiological mechanisms responsible for the edema formation are essentially the same in many of them. Since the composition and the spacial localization of the body fluids, as well as the general conditions determining their exchanges, have been so thoroughly discussed in recent years by Gamble,[3] Peters,[9] and others, it is unnecessary to describe these basic concepts here. However, knowledge concerning the various forces which govern the exchanges of water between the blood vascular system and the body tissues is so important for a proper understanding of the edema problem, that brief reference must be made to this aspect of the subject.

The chief factors known to favor the development of edema are the following:

1. Imbalance between
   (a.) Hydrostatic or filtration pressure within the capillaries (relative increase) and
   (b.) Colloidal osmotic pressure of the blood plasma (relative decrease)
2. Increased colloidal osmotic pressure of interstitial fluids
3. Decreased extracapillary tissue pressure (hydrostatic)
4. Decreased tissue elasticity
5. Increased capillary permeability (e.g. from malnutrition, local anoxia, toxic or allergic injury and increased environmental temperature)
6. Increased intake or retention of sodium salts
7. Obstruction of lymphatics

While the first of these factors, which was originally described by Starling,[3] is by all odds the most important in the average case of generalized edema, some of the other abnormalities almost invariably accompany it at one stage or another. The diagnostic appraisal of such cases is incomplete and the results of therapy are often unsatisfactory, if the coexistence of these minor physiological disturbances is not taken into account.

According to our present knowledge, the fluids of the body are divisible into two general kinds, one *intracellular* and the other *extracellular* in location. The former, which comprises between 65 and 70 per cent of the total body water, is further characterized by its relatively high content of proteins, potassium, and phosphates and, under normal conditions, by its almost complete lack of sodium and chloride. Exceptions to this latter generalization are found in the case of the red blood cells, the renal epithelium and the special secretory cells of the gastrointestinal tract. These are relatively unimportant, however, from the viewpoint of the total water balance. The *extracellular fluid,* which is characterized by its relatively high content of sodium and chloride and its comparatively low content of potassium, is further divided into the intravascular and interstitial compartments. These differ from each other only slightly as regards their electrolyte and organic crystalloid composition but differ greatly in their protein content. The blood plasma normally contains between 4 and 5.5 per cent (by weight) of albumin and between 2 and 3.5 per cent of globulin in addition to from 0.2 to 0.4 per cent fibrinogen; whereas, the interstitial fluid, an ultrafiltrate of plasma, contains but a small fraction of 1 per cent of protein. Maintenance of this difference is of the greatest significance for the normal exchange of fluid between these extracellular fluid compartments. The total osmotic pressure exerted by the intravascular colloids normally amounts to between 22 and 25 mm. of mercury. The serum albumin, having a much smaller molecule than the globulins, exerts an osmotic effect between three and three and one-half times that of the latter fraction on the basis of percentage content. The hydrostatic pressure within the capillaries is normally somewhat greater than the colloidal osmotic pressure near their arterial ends.

Normally the balance between the effective hydrostatic pressure (hydrostatic pressure of

plasma minus hydrostatic pressure of tissue fluid) and the effective colloidal osmotic pressure (osmotic pressure of plasma minus osmotic pressure of interstitial fluid) is such that essentially protein-free fluid is forced from the blood stream into the tissue spaces near the arterial ends of the capillaries and from the tissue spaces back into the capillaries near their venous ends. As the blood flows through the capillaries, the plasma proteins, to which the plasma colloidal osmotic pressure is almost entirely due, gradually become more concentrated as a result of the outward flow of water and at the same time the hydrostatic pressure gradually decreases toward the venous end of the capillary bed. It is obvious that fluid is drawn back into the capillaries at a normal rate only when the colloidal osmotic pressure of the plasma exceeds the falling hydrostatic pressure. Edema occurs, when, for any reason, the hydrostatic pressure within the capillaries is increased beyond a certain level (the protein concentration remaining unchanged), or when the serum proteins are decreased below a critical point (in young children approximately 2.0 $\pm$ 0.25 per cent albumin or 5 $\pm$ 0.25 per cent total protein) without a corresponding fall in hydrostatic pressure. The critical protein level for edema formation may vary somewhat as a result of the other factors included in the foregoing list. Increased intracapillary hydrostatic pressure is observed clinically almost exclusively as a result of increased venous pressure, not being materially affected by arterial hypertension until the general arterial pressure approaches a level of 300 mm. of mercury.

Clinical Disorders in Which Edema Presents a Special Problem

Cases of edema seen in practice or in the pediatric clinic can be classified most conveniently according to the predominating physiological mechanism responsible for the water retention. The most prominent general group is that in which hypoproteinemia plays the predominant role. The second in importance is that in which the edema is due primarily to increased venous (and capillary) pressure. The third is a miscellaneous group presenting evidence of increased capillary permeability due to toxic or other injury. A fourth and more distinct group is that in which extensive obstruction of the lymphatic system accounts for the fluid retention. In addition there are many mild cases in which several of the above factors contribute to the edema formation simultaneously but without any single one consistently predominating.

Hypoproteinemic Edema—Cases of edema due primarily to a reduction of the plasma proteins and consequently to decrease in the colloidal osmotic pressure divide themselves into several subgroups according to the cause of the hypoproteinemia. These are as follows: (1) those due to a dietary deficiency in protein (starvation edema); (2) those having an adequate intake of suitable proteins but suffering from impaired digestion and absorption of these food essentials, (3) those receiving, digesting and absorbing adequate protein but suffering from impaired ability to fabricate serum proteins and (4) those who lose serum proteins from the body (by way of the kidneys, great serous cavities or through seepage or drainage from extensive burns or other lesions) at a greater rate than they can be fabricated. Obviously there may be some degree of overlapping of these clinical groups.

Nutritional Edema—Numerically the most important of these groups is by all odds the first, namely, the type due to inadequate protein intake. In some countries, such as China and India, where famine has long been common, in others where war has imposed prolonged periods of partial starvation, and in regions (such as parts of our own Southern States) where dietary habits among the poorer members of the population involve an inadequate intake of protein, nutritional edema is particularly common among the children. Their protein requirements are far in excess of those of the adult members of the population because of the special demands imposed by the growth factor. The globulin fraction of the serum protein is reduced in severe starvation edema but less strikingly than the albumin fraction. In this type of case the diminution of serum proteins represents but one of the important abnormalities present. As pointed out by Weech,[14] the total amount of hemoglobin and of body-cell proteins are likewise greatly reduced. An accompanying vitamin deficiency may also complicate the picture. This is particularly important if the thiamin intake has been inade-

quate. Cardiac insufficiency of the beriberi type is not infrequently a contributing factor.

The treatment of pure nutritional edema consists of giving the patient a diet low in sodium chloride content but high in proteins and the various vitamins. The food proteins found by Whipple and his associates,[4] to have the highest serum-protein regenerating values should be given if selection is possible. Next to blood proteins, liver, soybeans, muscle and milk proteins stand highest on the list. Intravenous plasma or whole blood transfusions and infusions of amino acids may be employed to advantage in severe cases as emergency measures.

Hypoproteinemic Edema Due to Impaired Digestion and Absorption of Proteins.—This condition occurs not infrequently in children suffering from such disorders as chronic diarrheas, chronic acinar or cystic pancreatitis (celiac syndrome) or high intestinal enterostomy. The final effect of these conditions is similar to that in starvation edema. Cases representing these subgroups are seen from time to time in all large pediatric clinics. Obviously treatment of the edema consists of building up the protein level of the serum primarily by the intravenous administration of whole blood (particularly if anemia is present), plasma or amino acid solutions while attempting to remove the underlying disability.

One of our most recent cases with severe edema illustrates the findings to be expected in patients falling into the foregoing category. The patient, an 18-months-old girl, had shown anorrhexia, vomiting and diarrhea for three and one-half months before admission. Marked edema had developed gradually during the last three weeks of this period. Albuminuria or signs of cardiac disease had been looked for repeatedly by the family physician but were never found. Nor were they ever present during the month of hospitalization before her death. Since extensive cortical atrophy of the adrenal glands was found at autospy, it was presumed that this disorder was the underlying cause of her anorrhexia, vomiting and persistent diarrhea.

Before any plasma was administered the total proteins of the serum ranged between 3.18 and 3.70 per cent, both fractions being greatly reduced (albumin varying between 1.9 and 2.3 per cent; globulins between 1.03 and 1.5). The hemoglobin was reduced to approximately two thirds of the normal value. The blood ascorbic acid value was 0.5 mg. per cent. Hypoprothrombinemia was likewise present but no tendency to hemorrhage had occured. Plasma cholesterol was reduced to 93 mg. per 100 c. When the patient was being given a mixed diet by gavage, the stools were somewhat bulky and showed fat to constitute around 40 per cent of the total dry matter (normal below 17 per cent). After 360 cc. of four-times concentrated plasma and 300 cc. of whole blood had been given in the course of several days, the edema completely disappeared. At no time did the total serum protein value rise above 4.97 per cent, however, the albumin being 3.08 per cent and the globulin fraction 1.89 per cent at the time of the diuresis. Since the total amount of plasma protein given intravenously within a few days amounted to more than three times the total quantity circulating in the blood stream of a normal child at this age, it is apparent that much of that injected must have been catabolized or utilized to replenish other stores of body protein. A larger part of that injected than is apparent from the comparatively small increase in percentage of proteins in the serum probably remained within the vascular system. There it probably served to restore a somewhat shrunken blood volume. This fraction would, however, account for a minor part only of the extra proteins given. What role the factor of cortico-adrenal insufficiency *per se* might have had in the production of edema, aside from its apparent responsibility for the occurrence of anorrhexia, vomiting and diarrhea, was not suspected until a few days before death. Specific therapy was given but was ineffective.

Hypoproteinemic Edema Due to Impaired Ability to the Liver to Fabricate Serum Proteins.—This condition has now been thoroughly established as a clinical entity. The concept involved in the characterization of this group of cases was first enunicated by Thompson, Ziegler and the author,[13] in 1932 in connection with a case study and was more completely reported by these authors and Bell,[12] in 1936. A considerable number of reports of similar nature have been published since that time.

A two-year-old girl, who had shown generalized edema of gradually increasing severity for more than a year prior to her admission to the University of

Minnesota Hospital without ever having had albuminuria, cardiac insufficiency or disease of the gastro-intestinal tract. Her diet, carefully supervised from the time of her birth by a well-trained pediatrician, had always been taken well and had always been quite adequate in protein and vitamins. The general growth and development had been essentially normal in spite of the edema.

After it was discovered upon her admission to our Pediatric Service that her serum proteins were symmetrically decreased to less than half of normal values, she was maintained on a high protein (and otherwise complete) diet for six months during which time nitrogen balance studies were carried out. In spit eof her showing a strongly positive nitrogen balance consistently throughout this period without vomiting, diarrhea, proteinuria or loss of protein by way of the asctic or pleuritic fluids, there was no evidence whatsoever of increased production of serum proteins. The hemogoblin and blood lipids were maintained at normal levels and somatic growth proceeded normally. It was then tentatively concluded that the fault lay in a specific inability on the part of the patient to manufacture serum proteins at a rate sufficiently rapid to maintain a level above that which is critical for edema formation. Disease of the liver was suspected, but jaundice or other signs of hepatic insufficiency had never been observed and the various clinical tests for impairment of liver function revealed no further evidence to support this assumption.

Plasma proteins given by vein in amounts calculated to elevate the level in her serum above that considered to be critical for the development of edema, caused a marked diuresis with complete disappearance of the edema. The serum albumin level rose from 2.09 to 3.08 per cent and that of the globulins from 0.45 to 2.82 per cent as a result of the blood transfusions. In contrast with the emaciated appearance of children who have suffered from general malnutrition as well as edema after the latter has suddenly been eradicated, this patient resembled a normal child, except for excessive wrinkling of the skin in areas where it ordinarily occurs in loose folds. Although no further transfusions were given, the patient remained free from edema for a number of weeks. The serum proteins then fell gradually and mild edema recurred. At this time she contracted scarlet fever and developed acute otitis media and mastoiditis which caused her death. Postmortem examination revealed no visceral lesions other than *widespread atrophy or necrosis of liver cells* which appeared to have been present for a long time. There was no inflammatory reaction in the liver.

Other forms of liver diseases may also reduce the capacity of this organ to produce serum proteins and so lead to the development of edema. Myers and Keefer,[8] have presented evidence that this factor, as well as loss of circulating protein by removal of ascitic fluid in large amounts, often plays an important role in the hypoproteinemia and edema commonly occurring in adult patients with severe hepatic cirrhosis.

While cirrhosis of the type seen in adult life is not common in children, when it does occur in the latter, the complication referred to should be looked for. The author saw one such case in a Chinese child at the Peiping Union Medical College, but the edema may well have been due in part to deficiency of protein in the diet. At the same institution, however, two young infants suffering from congenital syphilis with extensive involvement of the liver developed marked hypoproteinemia and edema without albuminuria in spite of what was considered to be an adequate intake of protein. When one of the patients died, autospy revealed marked destruction of the liver by the primary disease. The other patient responded well to specific antileutic therapy and blood transfusions. The edema finally disappeared entirely, not to recur after transfusions were discontinued.

That severe chronic passive congestion of the liver can result in impairment of the serum-protein-fabricating function is best exemplified by the findings of Stadler and Stinger,[10] and those of the author,[5] in cases of chronic constrictive pericarditis. In both of the cases reported the incapacity of the liver to produce serum albumin and globulin was thoroughly demonstrated. These two case studies supplemented each other most satisfactorily to complete the evidence in favor of the contention that the liver plays the primary role in the production of serum albumin and probably of globulins also. The author's case showed complete recovery of the ability to fabricate serum proteins following relief of the passive congestion of the liver by means of surgical pericardiolysis. The case of the other authors showed extensive destruction of liver tissue at autospy.

Hypoproteinemic Edema Due Primarily to Excessive Loss of Serum Proteins.—This condition is more common in the United States (except for certain areas in our southern states) than any of the foregoing types. This group includes cases of nephrosis, chronic nephritis, extensive burns and all other conditions in which there is extensive loss of proteins by way of the urine, abraded skin and serious cavities. Since *"lipoid" nephrosis* is the most interesting and challenging representative of this series of disorders, problems concerning it will be considered in more detail than is feasible for other members of the group.

The primary etiology of this disease, which occurs most frequently in children between eighteen months and six years of age, is still obscure in spite of many scientific investigations

designed to explain its pathogenesis. While most attention has been directed toward the possibility that it is essentially a disease of the kidneys due to infections of various types, the evidence for such an assumption is not entirely convincing. The predominating frequency with which the pneumococcus is recovered from the nose and throat and from peritoneal exudates, when complications such as acute peritonitis and rhinopharyngitis occur, has suggested to some observers that this organism is the causative agent. However, its frequent absence in typical cases of the nephrotic syndrome and the extremely small incidence of nephrosis among the total number of patients suffering from severe pneumococcic infections, indicates that some other determining factor must exist, even if the pneumococcus should play a prominent secondary role in many instances.

Many data now available suggest that the kidney changes and albuminuria are secondary to a more profound, though admittedly obscure, disturbance in metabolism. The characteristic hyperlipidemia suggests liver disease or hypothyroidism. It should be noted, however, that the "corrected" basal metabolic rate is usually not greatly decreased in nephrosis and that intensive therapy with the thyroid hormone does not cause reduction of the hypercholesterinemia of nephrosis as it does in typical hypothyroidism. Nor are the serum proteins elevated as a result of such therapy.

It has been suggested by several investigators that serum albumin is excreted by the kidneys in large amounts in nephrosis because its chemical constitution is abnormal, causing it to be treated like a foreign protein. This view is supported to a certain extent by electrophoretic and immunochemical studies. It has also been reported that the urinary protein of nephrotic subjects is comparatively poor in sulphur and that the albumin of both the urine and the serum of these patients contains less cystine than does normal albumin. As a patient showing such abnormality improves, the character of the serum albumin is said to return to normal.

Additional evidence in favor of the theory that nephrosis is primarily a disease of metabolism, involving hepatic dysfunction, is found in the recent discovery by Farr,[2] of hypoaminoacidemia, particularly during exacerbations or "nephrotic crises." He found the blood amino acids to be 2.5 mg. per 100 c.c. under the latter conditions as compared with normal values of 4 to 5. In such crises the patient shows increased albuminuria, fever, nausea, vomiting and increased edema. With recovery the blood amino acids are found to return to normal. It is possible that particular amino acids, such as those containing sulphur (cystine and methionine) are especially deficient. General malnutrition is undoubtedly a prominent factor in most long-standing cases.

Treatment of Nephrosis

As might be implied from what has already been said regarding the obscurity of its etiology, treatment of nephrosis is largely symptomatic, no form of specific therapy having as yet been discovered. It consists of attempts to improve the patient's nutrition, to restore lost serum proteins, to combat complicating infections and to relieve accompanying symptoms. So long as edema and albuminuria of more than mild degrees are present, the patient should be kept in bed isolated from other individuals who are suffering from acute infections of any type.

On account of the chronic anorexia and associated general malnutrition usually present, special attention should be given to the need for supplying all dietary essentials in one way or another, gavage by means of an indwelling nasal tube being resorted to temporarily if necessary. Because of the excessive loss of albumin in the urine and the resulting drain on the serum proteins and undoubtedly on some of the body proteins as well, the daily diet should contain from 3.0 to 3.5 grams of protein per kilogram of the patient's expected or normal weight. The major portion of this protein should be derived from animal rather than from vegetable sources. Theoretically, liver feeding might be regarded as being especially desirable. While it is undoubtedly wise to restrict the sodium chloride intake somewhat, severe anorexia and even more serious effects of sodium and chloride deprivation result, if the patient is given none at all. Between one and three grams of this salt per day, which probably satisfies the basal requirements of young children, should be allowed. Vitamins can easily be given in concentrated form by mouth or even parenterally. The amounts of the various vitamins required per day under

ordinary conditions by young children are as follows: vitamin A, 4000 international units; thiamine chloride, 2 milligrams; riboflavin, 2 milligrams; nicotinic acid, 10 milligrams; ascorbic acid (vitamin C), 50 milligrams and vitamin D, 400 to 800 international units. Many patients with depleted stores of vitamins as well as proteins, require still higher doses at the outset. The diet *actually taken* by the patient should be examined carefully from the viewpoint of vitamin, as well as protein, intake. Supplements should then be administered to make up any deficiencies found by comparison with this list.

In some instances amino acids can be given advantageously by stomach tube or intravenously in the form of a 10 per cent solution of casein hydrolysate during periods of exacerbation, when the blood amino acid level is low and when the patient's appetite does not permit him to take sufficient protein my mouth. Farr has reported exceptionally favorable results from this procedure in one series of cases. In our experience with attempting to satisfy the patient's excessive needs for amino acids solely by intravenous administration, the results have been somewhat discouraging. Febrile reactions and further impairment of appetite have been the most common untoward responses. However, further refinements in technique may make this a more satisfactory form of temporary therapy. No matter whether amino acids or blood proteins are given, glucose should be administered at the same time in amounts necessary to prevent utilization of the amino acids or the proteins merely to supply needed energy. According to the work of Whipple, Madden and their associates,[4] serum proteins given intravenously are metabolized and so may also furnish building material for the fabrication of new cellular proteins as well as serum proteins.

For reducing the edema a large variety of procedures have been used with varying degrees of success. No one method has been uniformly successful, even when repeated in the same patient. In addition to the measures already referred to, the following have been employed:

1. Whole blood or unmodified plasma transfusions.
2. Concentrated blood serum or plasma given intravenously.
3. Gum acacia or pectin solution (8 to 20 per cent) given intravenously.
4. Sustained pituitary antidiuresis followed by abrupt withdrawal of the antidiuretic to precipitate diuresis.
5. Use of urea or of purine and mercurial diuretics or combinations of the latter.
6. Artificial fever therapy and protein shock therapy.

Of these measures, whole blood and concentrated human serum administrations are the most logical and the safest forms of treatment. They tend to make up for serum protein losses while improving nutrition and possibly increasing resistance to infection. Reduction of edema frequently results, if the level of serum protein is thereby elevated above the critical level for edema formation. Unfortunately, much of the serum protein is frequently lost in the urine almost as rapidly as it is administered. In this event, diuresis does not occur and the edema is unaffected. In long-standing cases much of the injected serum protein is undoubtedly utilized to restore the depleted protein of the body other than the circulating proteins. Under these conditions enormous quantities of concentrated plasma or serum are likely to be required, making the cost of such treatment almost prohibitive.

Gum acacia solution may cause diuresis by raising the colloidal osmotic pressure of the blood plasma, but is not infrequently followed by serious reactions and the gum is now known to be deposited as a foreign body in the liver and elsewhere in the tissues for long periods of time. Increase in albuminuria following the injection of gum solutions has been reported. This results in a further loss of serum protein, which is obviously undesirable and contraindicates the use of this procedure, excepting as a last resort.

Having observed in our clinic a net loss of extracellular body water in non-edematous epileptic subjects with low NaCl intake when pitressin (the post-pituitary anti diuretic hormone) was withdrawn following a twenty-four-hour period of sustained pituitary antidiuresis,[6] we subjected a series of nephrotic children to the procedure.[7] In a number of those whose serum proteins were ranging but slightly below the critical level, edema was strikingly reduced during the post-pitressin period of diuresis. The mechanism of this response involves the negative balance of sodium and chloride induced by the pitressin, but this is perhaps not the only factor of importance. Although the degree of edema was temporarily increased during the period when pitressin was

being given, no other untoward symptoms were observed and the patient's appetites and general behavior improved markedly after the diuresis was completed. Patients with the nephrotic syndrome superimposed upon severe chronic nephritis of various types with marked impairment of renal function likewise showed a post-pitressin diuresis but usually only a small net loss of body water. The method is not one of first choice even in so-called pure nephrosis, but may be given a trial after the other more physiological procedures have failed.

Often, when other methods of reducing edema have been tried in vain, diuresis may be induced by administration of urea in large doses (5 to 15 grams by mouth every six hours) or by a mercurial or purine diuretic. Intramuscular injection of salargan or of a combination of such a mercurial with a purine diuretic (e.g. mercupurin) appears to be the most efficacious diuretic in this type of case. The mercurial diuretics should not be repeated too frequently, however, because of the danger of further injury to the kidneys. Fever therapy and protein shock therapy have been advocated but are too severe to be used in seriously sick cases of nephrosis. Young children in particular respond unfavorably as a rule to these latter procedures.

At times ascites and pleural effusions become so distressing to the edematous patient that paracentesis and thoracentesis are indicated. Fluid should then be removed by means of a small trocar, most rigid precautions being taken against the possibility of infecting these cavities. In the presence of complicating infections in the peritoneal cavity or elsewhere, sulfadiazine, penicillin or other specific chemotherapeutic agents should be administered according to the type of microorganism found to be responsible. Fresh blood transfusions are likewise indicated in the treatment of such complications, particularly if anemia is also present.

The mechanism of the spontaneous diuresis, which is occasionally observed in nephrotic patients shortly after the onset of a complicating acute febrile illness, is not as yet adequately understood. The well known increase in fibrinogen (and less constant increase in the serum globulins as well), which is produced as a result of an acute infection, might conceivably elevate the colloidal osmotic pressure of the plasma above the critical level for edema formation if this was previously but slightly below it.

Orthostatic Albuminuria

While far more common in childhood than in adult life, Orthostatic albuminuria ordinarily does not cause hypoproteinemia of a sufficiently severe grade to produce edema. However, one such patient, a ten-year-old boy, was referred to the author by the family physician who had treated him unsuccessfully for more than a year as a case of chronic nephritis with edema. Special tests for orthostatic albuminuria were performed because no signs of nephritis other than the albuminuria could be found. In spite of the comparatively heavy cloud of albumin found in the urine at the time of the first examination, none was present in the fourth and fifth specimens collected at hourly intervals while he lay in a recumbent posture. His serum albumin was then found to be 2.1 per cent and the globulins 2.4 per cent. A medium-sized transfusion (300 c.c.) of whole blood caused complete disappearance of the edema.

Edema in Children Due Primarily to Increased Hydrostatic Pressure

Any condition resulting in partial obstruction of the venous return of the blood, whether local or general in distribution, tends to elevate the venous pressure and consequently the intracapillary pressure to levels which may exceed the normal colloidal osmotic pressure.

Cardiac Edema.—In our part of the world congestive heart failure with edema occurs in children most commonly as a result of uncontrolled rheumatic carditis. Chronic constrictive pericarditis or Pick's disease and congenital cardiac disorders with or without superimposed bacterial endocarditis are less frequent causes. While, so far as is known, there is no tendency for congenital heart disease to occur more frequently in one part of the world than in another, rheumatic carditis has a well-defined geographical distribution, occurring only rarely in the tropics and in northern Asia, but with alarming frequency in certain parts of Europe and in the northern part of the United States and Canada.

Increase in hydrostatic pressure within the peripheral veins and the capillaries is the chief mechanism involved in the production of edema

in the average case of cardiac insufficiency. However, hypoproteinemia may also occur in the more chronic cases as a result of malnutrition, low-grade albuminuria, and long-standing passive congestion of the liver, which impairs this organ's ability to fabricate serum proteins. Obviously, *treatment* of this type of edema is directed primarily against the underlying circulatory failure and secondarily against any accompanying abnormality, such as malnutrition and anemia. Therapy for chronic rheumatic carditis with myocardial insufficiency consists of bed rest, the oxygen tent when needed, complete diet with a low sodium chloride content and the administration of digitalis, diuretics and blood according to special indications. Surgical pericardiolysis is the only satisfactory treatment for chronic constrictive pericarditis.

Other forms of edema, in which increased hydrostatic pressure within the capillaries constitutes the chief feature of the edema mechanism, which as venous obstruction from cirrhotic changes in the liver, extensive venous thrombosis, arteriovenous aneurism and pressure from pelvic or mediastinal tumors, are occasionally seen in children but are rare in comparison with the frequency of their occurrence in adult life.

Lymphedema.—This is a form of localized edema due to obstruction of the lymphatics, seen occasionally in children. It occurs most commonly in one or both of the lower extremities, although the upper extremities and the head may also be involved. Infections, trauma and pressure of enlarged glands or tumors are the most common causes of the obstruction. A congenital form which most frequently affects one lower extremity only, making it larger than the other, apparently results from some developmental anomaly of the lymphatic system. Since the serum protein escaping into the interstitial spaces finally returns to the blood by way of the lymphatic system when the latter is blocked, such protein tends to accumulate in the retained fluid. One distinguishing feature of the edema fluid in chronic lymphedema, therefore, is its excessively high protein content—this amounting to as much as 3 or 4 per cent in some instances.[1]

Conservative therapy for lymphedema consists of elevation of the afflicted extremity when possible or use of a soft supporting bandage applied from the tip of the extremity, when the patient is ambulatory. Surgical treatment is obviously indicated in some cases. Every effort should be made in any event to prevent trauma and infection of the affected tissues.

The miscellaneous group of cases, in which the development of edema does not appear to depend primarily upon increased hydrostatic pressure, upon decreased colloidal osmotic pressure within the capillaries or upon obstruction of the lymphatics, are those in which evidence of increased permeability of the capillary walls can usually be found. The most clearly defined subgroup of cases placed in this general category are those suffering from allergic disorders. Urticaria and angioneurotic edema are examples. Fulminating acute infections, burns, certain toxic states, severe anoxia, insufficiency of some of the endocrine glands (e.g., the thyroid and adrenal cortex), chronic anemia and severe malnutrition (even without critical hypoproteinemia) predispose to the development of edema. Most of these conditions appear to do so largely because they impair the restraining function of the capillary walls. Decreased tissue elasticity is a minor factor in debilitated patients. The edema of acute glomerular nephritis appears to be dependent, in part at least, upon this mechanism of disturbed capillary function, although other factors, such as acute insufficiency of the myocardium, undoubtedly play a role in its production in this disease. Treatment of the edema *per se* is of secondary importance in most of the foregoing conditions, removal of the specific underlying abnormality being the essential aim.

Summary

The various physical forces and the pathological mechanisms of edema formation are discussed briefly. The roles of chronic malnutrition (due to protein and vitamin deficiencies in the diet or to faulty digestion and absorption of proteins) and inability of the body to fabricate serum proteins are given special emphasis. It is pointed out that nutritional edema, an extremely common condition among children in war-torn countries, serves as a fairly reliable index of the extent of undernutrition in such areas. Recent advances in our knowledge concerning the pathogenesis and treatment of nephrosis, chronic constructive pericarditis and congestive heart failure in children are likewise reviewed.

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MSMS

Office Treatment of Rectal Disease

By Andrew E. Souda, M.D.
Detroit, Michigan

Born in Palestine and graduated from the American schools in Jerusalem. B.S., Indiana University, 1926; M.D., 1928; Postgraduate work in gastro-intestinal tuberculosis cum laude, 1930; Specializing in Ambulant Proctology since 1934.

Most rectal ailments can be successfully treated in the office. It is as much a medical problem as a surgical one. Our apparent indifference and the fear of the knife on the part of the patient have encouraged nonmedical men to play havoc in this important field. Focal infection of rectal origin presents a territory yet unexplored, and the beginning of some major pathology in this area is sadly overlooked. The use of cathartics and enemas and oils would be drastically reduced when greater attention is rendered to the anus, rectum and lower colon.

Ambulatory proctology should become an important part of the curriculum in every recognized medical school.

■ THE reason ambulant proctology has been regarded with disfavor by many medical men has been due no doubt to the imperfection of its technique and because it is chiefly advocated by many incompetents and irregulars.

Why has this condition existed? Who is to blame? Is it not true that as medical students we are only exposed to the subject of rectal diseases as incidental to the teaching of General Surgery? Later in General Practice, unless our attention is drawn to complaints about the rectum, we are unaware of the existence of this focal area. Tonsils and teeth receive our scrupulous attention as a foci of infection. But the rectum and colon, although they may be possible secret agents sabotaging the blood stream with their Lavals and Quislings boring from within, we generally ignore. And, are there not many of us who have a distaste to local treatment of the ano-rectal region? Lastly, our attitude generally is: "You have hemorrhoids? Let us cut them out."

Our apparent indifference and the fear of the knife on the part of patients, have encouraged many irregulars and incompetents to draw on sufferers from rectal diseases with the exaggerated promises of no knife, no pain, no hospitalization, and above all—a life certificate of a permanent cure.

With some effort the general practitioner is well capable to handle most of the rectal conditions himself, for they are as much a medical problem as a surgical one.

Before discussing some of the more common rectal complaints and their treatments, may I point out a few factors worthy of our attention. Throughout its entire length the rectum is covered by three coats, mucous, submucous, and muscular; but the anterior and lateral walls of its upper portion have a fourth covering—the serous or peritoneal. Its mucosa is a continuation of the mucous membrane of the sigmoid.

The submucous coat contains blood vessels, nerves, and lymphatics. Any condition that weakens the first coat, which is the mucous coat (or the supportive layer), through pressure or irritation, would naturally produce an obstruction of the circulation of the rectal veins (which lack valves) thus retarding the return of the venous blood to the liver and causing varicosities of the veins, or hemorrhoids. May we keep this in mind when the injection treatment is discussed.

Most of the nerves above the ano-rectal line belong to the sympathetic nervous system. Please note that this accounts for the absence of pain above this area although we may have extensive pathology, whereas a minor lesion is quite painful at or below this important land-mark. When a

Delivered at the Postgraduate Session of the Florence Crittenton Hospital General Practice Division, November 17, 1942.

patient comes to you complaining of a tired feeling, gastro-intestinal disturbances, vague ulcer symptoms, unconfirmed gall-bladder pathology, sacral backaches, arthritis, painful, scanty, or even profuse menses, or urinary disturbances and you have given this patient a careful examination including x-rays and other tests, and although the patient does not complain of the rectum, look there: it may be the focal point you are looking for. From our limited experience we are convinced that focal infection of rectal origin presents a territory yet unexplored. May we add, that one diagnosis of an early adeno-carcinoma of the rectum or sigmoid will more than compensate for the time and effort which a thorough study of the ano-rectal region would involve.

Then, we have the muscular coat, the inner circular and outer longitudinal. Both are continuous with those of the sigmoid and colon. We shall touch on that point later.

Hemorrhoids and Their Office Treatment

Regarding hemorrhoids, we have three kinds: internal hemorrhoids or those occurring above the ano-rectal or muco-cutaneous line, external hemorrhoids or those found below the ano-rectal line, and mixed hemorrhoids—a combination of both. The internal type is most frequent. Due to engorgement, overdistention, trauma or erosion of the mucous covering we may have a considerable bleeding. Later on the mucosa may become tough and the bleeding become less frequent. Some internal hemorrhoids do not prolapse. Others prolapse at defacation but return spontaneously or with a little help. There is a third group of internal hemorrhoids which can be reduced only with difficulty. If not reduced they become strangulated.

A case of uncomplicated internal hemorrhoids, in our opinion, is curable with the injection treatment.

Treatment.—First, it is essential that the hemorrhoided area be exposed to view so that it may be easily accessible for treatment. We find that the Dickerson-James-Hinkle proctoscope gives us the best results.

Second, we need a hemorrhoidal needle attached to a 10 c.c. syringe; and thirdly, the solution we are going to use. A word about this item: Originally, strong solutions of phenol were utilized resulting in sloughing of the hemorrhoid. This was attended with the danger of hemorrhage. At present reputable men advocate quinine and urea and condemn phenol in oil solution. Other equally reputable physicians advocate the 5 per cent Phenol Solution in Oil. Condemn neither, try both and still others, and use the one that suits best.

The patient is placed in the left lateral position with the knees drawn upward, and is asked to hold the right buttock with his right hand. The operator is seated behind. First an external inspection, then a digital examination is made. In absence of painful conditions, the proctoscope is well lubricated and is slowly inserted into the rectum as the patient is requested to bear down. The field is carefully looked over and a point is chosen for the treatment, either because of bleeding or greater prolapse. Before you proceed keep in mind these helpful suggestions:

1. Always replace the prolapsed internal hemorrhoid.
2. Locate the ano-rectal line. Then stay away from it, for this is the painful area.
3. Expose the area to be injected as fully as possible.
4. Insert the needle beneath the loose mucosa and not into the veins.
5. If the insertion of the needle causes pain —*stop*. You are close to a danger zone.
6. If the patient complains of pain during the injection—*stop*. The tissues may be over-distended.
7. Never exert force upon the piston. The solution should flow freely with a little pressure, and must show bulging, otherwise you may be in the muscle.
8. If a snow-spot appears at the point of injection, the needle is in and not under the mucosa.
9. Inject sufficient amount of the solution until the bulging of the mucosa shows translucency or striation.
10. Keep a record of the location of the injection and of the quantity of the solution used.
11. Do not inject fibrotic tissue.
12. Do not inject external hemorrhoids.

Usually, one or two injections will stop the bleeding. Repeat the injections at intervals of a few days. The result will be: That all the

loose mucosa is tightened up and fastened down upon the rectal wall by induced adhesion. Restoring support to the rectal plexes, the veins are contracted but not obliterated. The inflammatory induration will subside by resolution, restoring the tissues to normal.

Recurrence—Relapses occasionally occur in the injection treatment as well as following operative procedure. It is no one's fault. Time, hard work, constipation, child-bearing, et cetera are factors with which we must reckon.

Anal Fissure

An anal fissure is a tear in the anal mucosa. It is described by the patient as being of a tearing, cutting or burning character. It may be associated with a throbbing pain lasting from one-half an hour to several hours after a stool. Often it occurs posteriorly. The external sphincter muscle fibres do not decussate at this point, presenting weak support.

Cause of anal fissure may be trauma, stricture, constipation, strain, et cetera.

Treatment.—Put the muscle at rest and healing will follow. The following methods have proved effective:

1. Divulsion. Under ethyl chloride gently stretch the external sphincter but do not rupture it. Stretching relieves the spasm and healing follows. We do not use instruments or mechanical dilators. When the patient is completely relaxed you introduce the right rubber gloved index finger into the anal canal with a boring motion. As the muscle gives, a second finger is introduced and the motion is repeated; then a third and a fourth finger until complete relaxation is achieved. I appreciate the controversy that exists on this point. Try it for yourself—then pass on it. It has been very successful when done on nervous people and takes very little time.

2. If incision is necessary, local anesthesia is used. The area below and around the Fissure is infiltrated with two per cent Novacaine or any other solution you desire. When relaxation of the muscle is complete, an incision is made from the extreme upper end of the fissure down through the center into the sphincter extending well out onto the skin. The incision is made shallow at the upper end but is between one-fourth to one-half inches deep at its lower extremity, depending on the thickness of the muscle.

3. A third method is the deep posterior injection of an adequate amount of oil anesthesia. There are a number on the market. We use Propalcaine. The ampule is warmed in hot water and a two-inch No. 20 needle attached to a 10 c.c. sterile syringe is used. The left forefinger is inserted into the rectum as a guide. The needle is entered subcutaneously in the midline about one inch posterior to the anus. The needle is then passed deeply into the sphincter and the oil is injected slowly on one side and then on the other, finally under the fissure itself. The amount used is from 2 to 10 c.c. depending on the spasm and the thickness of the muscle. This is followed by gentle massage to spread the solution uniformly. Novacaine may be supplemented superficially, To remove a sentinel pile, trim the edges of the fissure, excise its base or incise it, thus leaving a clean, smooth, well-drained wound. The muscle is put at rest for a week and very seldom does a patient complain of after pain if sufficient oil anesthesia is used.

External Thrombotic Hemorrhoids

An external thrombotic hemorrhoid is an ovoid or round swelling around the anus containing one or more blood clots, usually very tender and painful. Its onset is sudden. Its cause: Rupture of a vein or veins in the perianal plexes due to constipation, strain, or no apparent cause.

Treatment.—A few drops of novacaine are injected just under the skin or mucous membrane covering the tumor. Then the tissues around and below it are infiltrated. The apex is grasped with an Ellis or a tissue forceps and an elongated section is removed with a pair of curved scissors and the thrombus or thrombi enucleated. The overhanging skin edges are trimmed away; bleeding, if any, is controlled and a sterile dressing is applied.

Other Rectal Conditions

Polyps.—A polyp can be snared off through a proctoscope often without anesthesia.

Hypertrophied Papillæ.—They cause many reflex disturbances due to their specialized nerve supply. They produce indefinite symptoms of

uneasiness and spasm and are most often associated with cryptitis. They are removed under local anesthesia and the infected crypt which often causes pricky sensation when present is treated likewise.

Pruritus Ani.—Its cause or causes are many. Correct any rectal pathology present. Don't overlook a small ulcer or abrasion in the mucosa of the anal canal. Establish drainage. Check urine for sugar. Use stilbestrol, powdered calomel, zinc stearate, potassium permanganate, et cetera and when you have done all this and more, occasionally you'll meet your Waterloo. Pray.

Fistula.—A fistula is a suppurating canal, resulting from a neglected abcess. It may have an internal opening or external outlet, or both. The tract may be straight, connecting both openings, or it may assume all sorts of deviations. Often there is more than one external opening and the tracts may pass forward on each side. But no matter how many external openings we have or the type of tracts present, deep or superficial, straight or with offshoots, horseshoe or half-moon, they all lead to one source, and that is, the original source of infection. The only treatment, in our opinion, is surgery.

Careful infiltration of the tissue is carried out. A grooved probe may be used as a guide. The tract or tracts (with their lateral offshoots, if present) are laid wide open. All the dead tissue curetted and the edges trimmed out onto the skin. A styptic pack is applied. This operation is carried out to within an inch of the external sphincter. Before healing is complete, the second stage is carried out. If the internal opening is superficial to the external sphincter, the operation is completed. If the internal opening involves the muscle, it is wise to go through its fibres by stages, allowing healing before going further. Never cut through the anal ring at one sitting.

Prolapse of the Rectum

Proplapse of the rectum may be partial if tissue consists of mucous membrane only, as is usually found in children, or involves a portion of the rectal circumference when it is associated with prolapsing piles. Or the prolapse may be complete if the entire thickness of the rectal wall is extruded and presents marked redundancy of the mucous membrane over the muscle coat.

Treatment.—You all know that many major operations have been described and practiced. Their basic principle is rectal fixation. Most of them are severe and the prognosis is not very encouraging. Since every case of prolapse, whether mild or severe, is accompanied by loose and redundant mucosa, and since the levator's ani and external sphincters constitute the strongest natural support of the rectum whose fixation is desired, we present two simple methods in treating this condition.

1. The prolapse is reduced and the proctoscope is inserted. The lax redundant mucosa is then injected with five per cent P. O. as high as possible. This is followed by a series of injections under the mucosa, spaced out as evenly as possible around the circumference of the rectum. When this is accomplished, further injections in like manner are given lower down. Between 15 to 20 c.c. of the solution is used. In children very much less. A mild antiseptic pack is left in the rectum and the patient sent home. On his return a firm diffuse enduration will be felt surrounding the rectum producing its desired fixation. Further injections are repeated within a few days if any loose mucosa is discovered.

2. Another method, while the prolapse is exposed, is to inject a few minims of 4 per cent Q. U. into the muscle coat in staggered rows. After the injections are completed the patient's protrusion is restored inside the sphincter, and the replaced bowel is packed with gauze saturated with one to three parts of Monsels, S. T. 37. This serves as an antiseptic and styptic for any slight bleeding that might occur from the punctured wounds. The patient is put to bed for 48 hours without food and given sedatives. After that the pack is removed and a soft diet is advised.

Constipation

We know that it takes four hours for the ingested food to travel through the small bowel from the pylorus to the cecum, and from fourteen to twenty hours to pass from the ileocecal valve to the recto-sigmoid juncture. On this second journey the waste product of the ingested food

(Continued on Page 508)

Billions and Bureaus

In the past ten or twelve years, we have been led to believe that there are only two remedies in the little black satchel. No matter what is wrong with you, if a billion won't cure you, a bureau will.

We must, with all possible fullness and tenderness, care for the weak and unfortunate among our people; but we must also be sure that the strong shall be kept active. Let us provide for the 20 per cent of our population who are the weak, and at the same time keep the other 80 per cent strong and independent. These are the people who want the privilege of earning an honest living and paying their honest debts and who, in the time of catastrophic illness, want to be taken care of through some type of protection which they have had an opportunity to provide for themselves, at a cost, not to exceed that which they would have to pay through taxation if government, through bureaus, furnished the same.

This nation will only be strong as it is made up of men and women who want the fine things of life, the protection for themselves and their families in sickness and in health; who know that these things must be worked for and sweated for, and paid for, and are not handed to them by a philanthropic government.

That precious heritage of freedom and struggle and free enterprize which our fathers fought and died for must continue; not only for our doctors of medicine, but for all the people of this great nation.

C. R. Keyport

President, Michigan State Medical Society.

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EDITORIAL

PAYS 20 PER CENT PRORATION

■ We announced very briefly last month that Michigan Medical Service is now out of the red. That was a goal set many months ago. We can now announce that machinery is in operation to repay the proration which we surrendered during the five months of 1941 when the continuation of Michigan Medical Service was a question in many minds. The present favorable financial condition is the result of unfaltering faith in a principle, and dogged persistence in carrying it out.

That Michigan Medical Service is filling a very substantial place with our employed groups is evidenced by the fact that just recently two thousand employes of a large Detroit concern walked out because they could not get Michigan Medical Service certificates. During the time of recouping that has just successfully passed, no large groups were sold the service, upon advice of the State Insurance Commissioner. He was unconvinced that the plan could carry out its obligations, so would not sanction taking on more subscribers. This group was told that fact, but would not be convinced until contact with the Department verified the statements.

Wisconsin is interested in a Medical Service plan and is starting one in a small way. The *Milwaukee Journal* sent a staff member to Detroit to study Michigan's plan, and published two articles in the Sunday issues of April 16 and April 23, 1944. There were six columns of favorable observations with some criticism. Editorially on April 16, 1944, they said:

"Erudite as it is, the organized medical profession of America has rarely shown brilliant diagnostic ability when examining its own ills. It has rather consistently taken the stand that the traditional American system of medical economics was sacrosanct. . . . But, unfortunately, the voice of 'Organized Medicine' when it comes to social rather than technical progress, has too often been the voice of those top bracket men of the profession whose talents or society connections have rewarded them richly and still permit them time to appear on convention programs and serve on committees that speak for the profession. . . . Now organized medicine has become greatly alarmed about 'radical' proposals for 'socialized medicine,' for 'contract medicine' and 'group medicine,' in all of which are supposed to lurk ominous perils for the practitioner and the patient. . . Happily, there has been some evidence of such concern here and there, now and then. Some of it is presented in this section of the *Journal* today in the article on Michigan Medical Service. There a State Medical Association threw itself wholeheartedly behind a plan which it felt could protect every legitimate interest of the profession and would still offer patients an easier way of meeting the costs of severe illness. . . . The plan cost the medical association a good deal of money, some severe headaches and much criticism, but more than 600,000 persons depend on it today to meet most if not all of their costs for such surgical and obstetrical care as they may need. . . . *The point is that the Michigan Medical Association, along with a very few other state groups, has done more than just see hobgoblins. It has struck out and done something.*" (Italics ours.)

This last sentence of the *Milwaukee Journal* editorial is the reason for the extensive quotation. If the grave present problems of the medical well being of the nation are to be wisely solved we all have to DO SOMETHING. We have for too long been fighting something. We have been opposed to some plan, but we have failed to put forth a counter plan, or come out with a real statesmanlike program to correct the faults and offer the aid and care that is being demanded by our critics.

We have suggested Michigan Medical Service as part of the solution. We believe it could be a real, substantial part of that solution, but more is needed: *We must tell our story to the world.* We must get the ear of the reading, thinking, active groups of our people and tell the story of public health, private health, sanitary advance, gains in records of mortality, morbidity—such stories as are now coming out of the medical part of the war, such stories as have been available but untold for the past few decades.

We need a book.

FIFTH WAR LOAN

■ The Fifth War Loan will begin on June 12, 1944, a very few days before this JOURNAL is issued. War bonds have become the most significant investment for all Americans. They are a

good investment, and a real help in winning the war. The popular twenty-five dollar bond has been sold so many times that there are said to be sixty-nine in issue for every dollar bill.

War bonds are the best advertised product in history, and without a cent of cost to the government. They are purchasable at more than a million places and we are confident that our members will buy them in increasing numbers. And while buying for yourself, *why not buy one also for the Michigan State Medical Society's Postgraduate Medical Education Foundation?*

The goal for the Fifth War Loan is $16,000,000. It will be necessary for us to buy to the limit, but what better cause could there be?

THE BUREAUCRATS

■ The committee of the Council which is negotiating with the Children's Bureau on the EMIC program, in carrying out the instructions of the House of Delegates at the annual meeting in September, 1943, is still at an impasse. The response from Washington is as always, NO. Several proposals have been submitted, and refused. The last information was a request from Washington for the committee to submit another proposal. There is scarcely an incentive to submit any more proposals to a bureau whose top man wrote its legal department asking it to find authority by which the Michigan plan could be rejected! Is there not some bureaucrat in Washington who would be interested in at least once finding something to do that would please the medical profession?

The Wagner-Murray-Dingell bills are quiescent. But is that a healthy sign? Are the bureaucrats allowing us to think they have retired from the fray in order to lull us into inactivity, so that they may by a sudden coup ensnare us more deeply. We cannot afford to be caught napping. We must keep the heat on this measure or it will be sprung when we least expect it, and in a way we cannot successfully protest. That was what happened in the EMIC affair.

The Bureaucrats are full of promises, at the cost of the government, which we forget is us. They must perpetuate themselves in power. A medical program for the whole nation is too juicy a proposition for them to surrender without a fight. Our patients are ready to help in most instances if we will but give them the chance. But they must be shown that this is their problem, more than ours. The plans of service for the doctors could be comfortable and satisfying to the man who is now pushed to the limit, but there are not half enough doctors in the country to service the plan as now proposed.

Something better is needed, and we think Michigan has again shown the way to what so far is the most promising solution. Private enterprise offers more opportunity than bureaucracy.

PHYSICAL MEDICINE

■ "Secretary Foster presented the recommendation of the Bay County Medical Society that the Executive Committee of The Council urge the Michigan medical schools to offer more training in Physical Medicine, as well as the recommendation to the MSMS Committee on Postgraduate Medical Education that it include lectures on Physical Medicine in the MSMS postgraduate extra-mural courses. Motion of Drs. Foster-Sladek that the Executive Committee communicate with the Deans of the two medical schools in Michigan urging them to stress the importance of Physical Medicine in their curricula and also to suggest to the State Board of Registration in Medicine that they likewise write the Deans of the medical schools on this subject; and further that the Committee on Postgraduate Medical Education be requested to include Physical Medicine in its courses for the physicians of Michigan; carried unanimously."—From minutes of the Meeting of the Executive Committee of The Council, February 24, 1944.

It is especially gratifying to the officers of the Michigan State Medical Society to note the articles appearing in the public press of April 27, 1944, announcing the gift of $1,100,000 by Mr. Bernard M. Baruch for the teaching of and research in physical medicine. An administrative Board under the Chairmanship of Ray Lyman Wilbur, M.D., Chancellor of Stanford University, has been established to inaugurate the program. Mr. Baruch's gift was animated by the belief that physical medicine has not been given the scientific treatment it deserves. His interest in the situation arises from two causes, because his father, Simon Baruch, M.D., a distinguished surgeon of the confederate army, had been a leader in the field in the College of Physicians and Surgeons, and because of Mr. Baruch's desire to do something for the sick, and especially the ill and wounded veterans.

Grants have been made to Columbia University to establish a key center of research and teaching, $400,000. Also $250,000 to New York University to establish a center for teaching and special research in preventive and manipulative structural

mechanics of physical medicine, and a like amount to the Medical College of Virginia for a teaching and research in hydrology, climatology and spa therapy. These are all for a ten-year program. Other sums are available to selected schools and for the establishment of Fellowships or Residencies.

Doctor Foster, the Bay County Medical Society, and the Michigan State Medical Society have placed an entering wedge for work along these lines in Michigan, and this announcement shows the trend. Michigan can also be proud of the fact that this program so closely follows the Battle Creek Idea which John Harvey Kellogg, M.D., used to establish a great institution, and an international reputation.

The Director of the Michigan Crippled Children's Commission reports that not 10 per cent of the doctors are collecting the fee of $1.50 provided by statute for the making out and signing of the original examination report to the Judge of Probate through which these children are hospitalized. It is necessary for the doctor to bill the Commission through the Judge of Probate.

* * *

Bills for services to patients under the afflicted and Crippled Children's Acts, should be made out in duplicate, one sent to the hospital, and a duplicate sent to the commission. This will obviate the failure of the hospital sometimes to send the doctor's bill.

OFFICE TREATMENT OF RECTAL DISEASE

(Continued from Page 504)

loses its fluid contents, and the nearer to the sigmoid the more solid the feces becomes. It rests at the sigmoid until ready to be passed out through the rectum and anus. Therefore, the trip would normally require about 24 hours. But retention is longer than that, of all or part of the waste product in the colon. Whether this retention is due to faulty digestion or mechanical obstruction, it brings about constipation or obstipation.

Let us review what could happen because of this condition:

1. The longer the fecal mass remains in the colon, the more of its toxic substances are absorbed into the blood stream, causing mental sluggishness, vertigo, dizziness, neuritis, rheumatism, etc.

2. Absorption of these toxic materials from the large bowel reaches the liver through the portal circulation and this results in biliary disturbances.

3. Abnormal presence of fecal material in the colon hinders the onward progress of gases and reverse peristalsis follows. The gas may be forced back into the stomach causing loss of appetite and a feeling of fullness or distension.

4. The liquid fecal material in colonic stasis produces inflammatory conditions of various types which often are responsible for appendicitis and colitis.

5. Constipation lowers the resistance of the individual to bacterial invasion. The success of bacterial invasion depends a great deal on the cleanliness of the colon.

Conclusion

Now these problems and many others are daily faced by the general practitioner, and he has many successful ways of meeting them. May we suggest that the rectum and colon be given greater attention. Physical examination should include not only an external or digital examination of the rectum but the proctoscope and sigmoidoscope should be as handy as a tongue depressor.

We do not intend to convey the impression that all human ills are centered in the lower bowels as is maintained by the Yogi philosophers of India, but we do believe that this field is sadly neglected and deserves greater attention. And we repeat that this subject must be a necessary adjunct in the armamentorium of the general practitioner.

This is the section where the ragweed pollen count is the highest of any section in the United States.

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(occurring during August and September)

Stock Formula material (no mixing, no diluting) ready when a diagnosis by scratch-testing is not possible.

Three vials are furnished in each set with unitages graded as follows: 100 units/c.c., 1000 units/c.c. and 10,000 units/c.c. A special vial (30,000 units/c.c.) may be obtained for perennial treatment where higher dosage is indicated.

Three important combinations are offered to suit the particular needs of your patients:

*Bio. No. 101: Large and Small Ragweed, 50% each.

Bio. No. 102: Large and Small Ragweed, 40% each, Cocklebur 20%.

Bio. No. 103: Large and Small Ragweed, Cocklebur, Marsh Elder and Wormwood.

*A.M.A. Council-Accepted

Extract of Poison Ivy-Sumac is available in 4-vial set and 15 c.c. size.

Send for a Barry Pollen-Pak especially assembled for your locality —contains 20 glass capillary tubes of local pollens and fungi.

SEND FOR Patients' Reminder Card for your office—complimentary!

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G. A. Ingram Co.
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Flint
Flint Medical & Surgical Supply Co.

Grand Rapids
Medical Arts Surgical Supply Co.

Jackson
The Chemist Shop

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The Drug Shop, Inc.

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Windsor, Ontario, Canada
G. A. Ingram Co.

Barry ALLERGY LABORATORIES, INC.

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YOU AND YOUR BUSINESS

SYNTHETIC QUININE

The war has cut off most of our supply of quinine, but has provided us with more need than ever for it. The *Journal of the American Chemical Society* for May, 1944, reports the successful synthesis of quinine by Drs. William E. Doering and Robert B. Woodward. This new material is not a substitute like atabrine or plasmochin, but is a precise duplicate and cannot be distinguished from the natural drug. If this be true, and it is well vouched for, the benefit to our returned soldiers and to those in the field will be untold.

Chemists have tried to duplicate the quinine of the cinchona tree ever since it was isolated in 1820, but without success. In 1856, William Henry Perkin tried to synthesize quinine. He used the proper number of atoms but threw them all together and got the dye Mauve, from which has sprung the organic chemical industry. Woodward and Doering used direct approach by bringing together the proper chemical groups in the proper way to produce a substance whose exact structure was known. They also produced a "mirror-image," an optical isomer, which may have great value, and is not found in nature.

MICHIGAN MEDICAL SERVICE

A recent public opinion survey indicated that 63 per cent of the American people are demanding a better way of meeting the high cost of serious illness. The doctors of Michigan are offering what seems to be a better way, and 625,000 persons are now covered by this physician-sponsored and physician-controlled plan under which the patient may buy some protection for himself against the expense of surgical and obstetric care.

As far back as 1929 the State Medical Association of Michigan began its search for some method by which the best medical service could be made available to more persons without excessive expense to the individual patient. After ten years of investigation and discussion the association sponsored enabling legistion which allowed nonprofit corporations as Michigan Medical Service to be set up with the state Insurance Commissioner supervising, but with doctors entirely in control of professional standards and fees.

No evidence was found that Michigan Medical Service has adversely affected the total income of any enrolled doctors. It may well be that some have found it a welcome solution for slow collections and others have found it paying more than the fees they had generally charged.

But it provides one answer to the demand for easing the burden of the expense of sickness. It appears to do so without interfering with present professional standards, or essentially with physician-patient relationship.—*Milwaukee Journal,* April 16, 1944.

ADDITIONAL FUNDS FOR EMIC PROGRAM

The President has transmitted to Congress two supplemental estimates for appropriations for the EMIC program.

1. He has requested an additional appropriation of $6,700,000 for expenditure during the fiscal year ending June 30, 1944. The Director of the Bureau of the Budget justifies this request as follows:

"This item provides funds in addition to $23,000,000 previously appropriated for fiscal year 1944, by Congress for grants to States for the payment of medical, hospital, and nursing expenses for maternity care and for infants of families of enlisted men in the armed forces of the fourth to seventh grades. The supplemental amount is required for allotments to States for authorizing such services during most of May and all of June: Without it the States will have to suspend authorizations."

2. He has asked for an increase of $22,800,000 in the appropriation previously requested for the fiscal year 1945. The initial request was for $20,000,000; the President now requests $42,800,000. The Director of the Bureau of the Budget justifies this increase as follows:

"The amendment increasing the estimate of appropriation is required to meet necessary additional obligations not provided for in the amendments transmitted by your [the President's] letter dated March 31, House Document 524, and the Budget for 1945.

"Estimates previously made of the requirements of this program for fiscal year 1945, were considered adequate on the basis of information then available. Succeeding events have materially altered the basic assumptions, and information recently made available to the Children's Bureau by Service Headquarters of the armed forces has caused the Bureau to revise its estimates for grants to States to take care of an increasing number of applications for care which are anticipated in 1945."

The foregoing estimates are pending in the House Committee on Appropriations (as of May 6, 1944).

THE FOOT IN THE DOOR

Someone recently asked if the EMIC Program is the foot of federalization in the door of Medicine's house. It is, judging by complementary activities in Washington, D. C. The present aim seems to be to increase veterans' hospitals and their capacity quite rapidly. It would appear that other legislation will follow from year to year to extend fuller hospital and medical services not only to veterans but to the members of their families. So 10,000,000 veterans, plus their families, will total some 30,000,000 to 40,000,000 who will be covered by some kind of socialized health service within the next two decades, according to political forecasters in the national capitol.

Congress may never pass the Wagner-Murray-Dingell Bill of 1943. But the same results—complete control

(Continued on Page 512)

(Continued from Page 510)

of Medicine and its practitioners—can be achieved by a series of amendments to important appropriation bills and resulting "directives" from active bureaucrats.

After this present wartime emergency, the "foot" must be withdrawn, and the door closed.

DON'T CASH STRANGERS' CHECKS

"Strangers are not always crooks, but crooks are usually strangers."

Always refuse to cash a check for a stranger without proof of his or her identity and title to payment. The better forms of identification are: an employe identification card or plant button, car owner's registration or driver's license (be sure and write the license number and state of issue on the check itself).

A sure "stopper" for a crook is to ask for the thumbprint to be pressed under the endorsement signature. Insist that checks be endorsed in your presence; then compare the new signature on the check with the signature on the identification card. Don't accept a social security card as final identification; remember that over 50,000 worn out or lost cards are being replaced each month. Finally, when an identified soldier or sailor requests you to cash his check, ask to see his identification tag which gives his name, address, and army serial number. Write these on the check, and ask the serviceman to write on the endorsement the name of the ship or station to which he is attached.

MIGRANT WORKERS

Migratory farm laborers working in the State of Michigan this summer and autumn will be provided with medical, dental and hospital care under the program of the War Food Administration and the Midwestern Agricultural Workers Health Association. The care will be provided in the same manner as was accomplished in 1943.

Only foreign and domestic workers who have a contract with the federal government and who are transported by the War Food Administration fall in this category. The Health Services Division, headed by a medical officer assigned by the USPHS, carries out an industrial hygiene and medical program adapted to migratory workers in the farming industry. The workers included in this program have received a physical examination which included an x-ray of the chest and serological test for syphilis. Workers showing lung pathology, infectious diseases, or physical disabilities are excluded from the program. For the most part, foreign laborers will be recruited in Mexico, Jamaica and Bahama, and will belong to medically indigent groups who are transient nonresidents.

The Midwestern Agricultural Workers Health Association, a nonprofit corporation, arranges to have medical care provided the workers by local physicians on a fee-for-service basis. No restrictions regarding the choice of physicians whose services are needed by the workers is imposed. The Association has no fee schedule; it merely requests physicians, dentists and hospitals to compute their fees on the basis of rates applicable to the medically indigent group of the community.

A F OF L EXPRESSES ITSELF ON BUREAUCRATIC DOMINATION

"Do we want a great bureaucracy to dominate American life after the war, with dictators like those we now have who can set aside collective bargaining agreements without even considering the facts on which these agreements are based? Do we want to be ruled by individuals from whose decisions there is no appeal? Do we want domination by the military? This is the Fascist way, not the American way. Yet the surest way to get this very dictatorship is to fail now to set up a democratic civilian agency to direct postwar policy, with assured representation of all groups concerned.

The above quotation was not culled from the publications of the United States Chamber of Commerce, the National Manufacturers' Association or the American Medical Association."

The original will be found in *Labor's Monthly Survey,* Vol. 5, No. 2, 1944, page one, publication of the American Federation of Labor.

If that is the policy of the A. F. of L. and the A. F. of L. actually means what that statement says, it can not, even by a stretch of the imagination, be for the Wagner Bill or similar proposals. Put the government in charge of medical and health programs, big or little, and you have a bureaucracy, big or little, dominating American life in one degree or another. If domination is bad in the field of labor-employer relations, it is bad also in any other field of human relations.—*Ohio State Medical Journal,* May, 1944.

The 79th Annual Session, MSMS, will be held in Grand Rapids, Wednesday, Thursday, Friday, September 27-28-29. The 1944 Postgraduate Conference on War Medicine will feature an outstanding program with 30 eminent lecturers from all parts of the United States and Canada. The Woman's Auxiliary will meet also. For hotel reservations write: Committee on Hotels, care of Pantlind Hotel, Grand Rapids.

LACTOGEN

approximates women's milk in the proportion of food substances

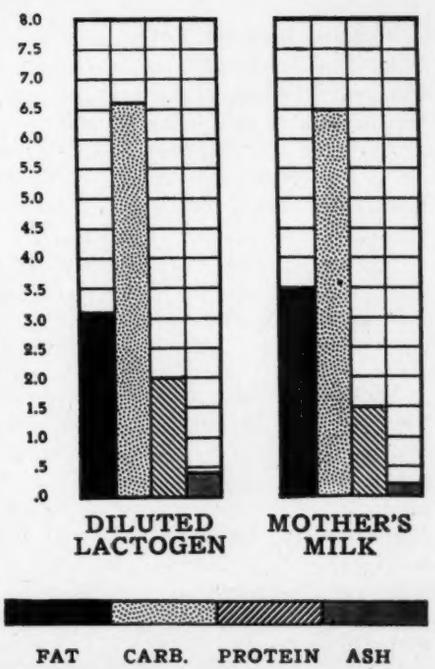
THE cows' milk used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water it results in a formula containing the food substances—fat, carbohydrates, protein, and ash—in approximately the same proportion as they exist in women's milk.

One level tablespoon of LACTOGEN dissolved in 2 ounces of water (warm, previously boiled) makes 2 ounces of LACTOGEN formula yielding 20 calories per ounce.

No advertising or feeding directions, except to physicians. For feeding directions and prescription blanks, send your professional blank to "Lactogen Dept."

"My own belief is, as already stated, that the average well baby thrives best on artifical foods in which the relations of the fat, sugar, and protein in the mixture are similar to those in human milk."

JOHN LOVETT MORSE, *A.M., M.D.*
Clinical Pediatrics, p. 156.



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IN MEMORIAM

Carroll S. Davenport, of Lansing, was born in 1898, in Dalton, Pa., and was graduated from the University of Michigan Medical School in 1922. He was resident and instructor at University Hospital from 1923 to 1925. In 1925, he came to Lansing as roentgenologist at St. Lawrence Hospital where he remained until the time of his death. An authority in his field, Doctor Davenport was a member of the Detroit Roentgen-Ray and Radiological Society, Michigan Association of Radiologist and a Diplomat of the American Board of Radiology. He died suddenly on April 26, 1944, while working at the hospital.

Stuart Lloyd DeWitt, of Grand Haven, was born January 1, 1889, in Spring Lake, and was graduated from the University of Michigan Medical School in 1911. He spent two and one-half years in Rhode Island General Hospital at Providence, R. I., serving his residency. He was well known not only in the medical profession but in the community because of his interest in the civic, education and fraternal life of Grand Haven. At the time of his death, he was a member of the board of education, chamber of commerce, and other organizations. He was a former president of the Ottawa County Medical Society. He died on March 28, 1944.

William Howard Force, of Ludington, was born in 1869, in Fowlerville, and was graduated from Wayne University College of Medicine in 1908. After graduation he located in Ludington and for nine years acted as health officer. He served as a captain in the medical corps in World War I. After spending many months following the war in postgraduate work in Chicago and at Harper Hospital, Detroit, Doctor Force returned to Ludington and entered private practice. He was active in many civic and fraternal organizations. He died on March 29, 1944.

Michael William Lash, of Detroit, was born October 13, 1913, in Detroit, and was graduated from the Wayne University School of Medicine in 1937. After graduation, Doctor Lash interned at Providence Hospital. In 1940, he completed a postgraduate course in Surgery at the University of Pennsylvania, after which he returned to Providence Hospital as the resident in Surgery. The following year he entered private practice, specializing in Surgery. Doctor Lash died April 8, 1944.

Frank Scott Tuthill, of Concord, was born in 1866, and was graduated from the University of Michigan Medical School in 1891. In July of that same year, he opened his practice in Concord. He retired in 1940 after practicing medicine for more than fifty years. Following his retirement, because of failing health, he was made president of the Farmers State Bank of Concord. Doctor Tuthill died April 18, 1944.

Robert J. Walker, of Saugatuck, was born in 1869, in Strathroy, Ontario, and was graduated from the Medical Faculty of Trinity University of Toronto in 1895. He started his medical practice in Saugatuck. Active in civic affairs, Doctor Walker served several years on the school board, was director of the Fruit Growers State Bank for thirty-five years, twelve of which, he was a member of the board of trustees. In World War I, he served as a lieutenant in the Medical Corps. He died December 11, 1943.

Arthur C. Wood, of Adrian, was born in 1872, at Lyons, Ohio, and was graduated from the Detroit College of Medicine in 1894. He began practice in Britton in 1906, and located in Adrian in 1909, where he served the community for thirty-five years. He died March 17, 1944.

John Mill Wright, of Grand Rapids, was born August 31, 1874 in Corinth and was graduated from the Detroit College of Medicine in 1895. He served on the staff of St. Mary's Hospital for many years and at the time of his death was chief of staff at Evangeline Home. He was an instructor at the old Grand Rapids Medical College for forty years. It had been his custom many years to spend three months each summer in study; he had studied in Paris, Vienna and Munich. At one time he served as secretary of the Kent County Medical Society. Doctor Wright died April 27, 1944.

Herbert V. Barbour, LL.B., of Detroit, for many years attorney for the Medico Legal Committee of the Michigan State Medical Society, died March 24, 1944. He was always interested in the problems of the doctor and ready at all times to be of aid.

MMS PAYS $127,000 PRORATION

The full amount of the sum which was withheld by Michigan Medical Service from its payments to physicians during part of 1941 will be repaid in June, according to Dr. R. L. Novy, Michigan Medical Service president.

The announcement by Dr. Novy said that checks totaling about $127,000.00 will be "in the mails" before the middle of June.

This important development will clear the Medical Service books of an obligation which occurred when, for five months nearly three years ago, it was necessary to reduce payments to physicians by 20 per cent.

"This repayment signalizes a milestone in the growth of Michigan Medical Service," Dr. Novy said. "We consider it conclusive evidence that our experimental period is ended, and that we have found the remedies to our early miscalculations. Michigan Medical Service retired its deficit several months ago, and we intend to keep it 'in the black.'"

Dr. Novy also pointed out that efforts are being made to strengthen the Michigan Medical Service subscriber contract and to make possible a greater participation by physicians whose part in the Plan has been limited in the past. This matter is under consideration by the Medical Service Board of Directors and the committees, he said.

✶ COUNTY AND PERSONAL ACTIVITIES ✶

100 PER CENT CLUB FOR 1944

Allegan—J. E. Mahan, Secretary
Alpena-Alcona-Presque Isle—E. S. Parmenter, Secretary
Barry—H. S. Wedel, Secretary
Bay-Arenac-Gladwin-Iosco—L. F. Foster, Secy.
Branch—James Bailey, Secretary
Clinton—T. Y. Ho, Secretary
Dickinson-Iron—E. B. Andersen, Secretary
Eaton—L. G. Sevener, Secretary
Grand Traverse-Leelanau-Benzie—Robert T. Lossman, Secretary
Hillsdale—John A. MacNeal, Secretary
Houghton-Baraga-Keweenaw—R J. McClure, Secy.
Huron—J. Bates Henderson, Secretary
Jackson—H. W. Porter, Secretary
Lapeer—H. M Best, Secretary
Livingston—Ray M. Duffy, Secretary
Luce—Sidney Franklin, Secretary
Manistee—C. L. Grant, Secretary
Mecosta-Osceola-Lake—John A. White, Secretary
Medical Society of North Central Counties—Stanley A. Stealy, Secretary
Menominee—Wm. S. Jones, Secretary
Midland—Ralph R Sachs, Secretary
Muskegon—Helen S. Barnard, Secretary
Newaygo—H. R. Moore, Secretary
Oceana—W. Heard, Secretary
Ontonagon—W. F. Strong, Secretary
Sanilac—E. W. Blanchard, Secretary
St. Clair—A. L. Callery, Secretary
Tuscola—John C. Shoemaker, Secretary

As of May 10, the above county medical societies have certified 1944 dues for every member of their respective societies, to be the first 100 per cent paid-up counties for this year. A number of other societies have certified all but one or two of their 1944 members. As soon as these have paid their 1944 dues the list of 100 per cent county societies will be much larger.

Flint has a new Health Council appointed by the Mayor which is making a study of hospitalization and care of the sick in Flint. The representative of the Genesee County Medical Society on the Health Council is F. B. Miner, M.D. of Flint.

* * *

The Macomb County Medical Society has developed a leaflet, "Facts About the Wagner Bill" which it is distributing, through its members, to the public. This appeal to "you, the patient" is one of the best briefs against the proposal for Political Medicine that has yet appeared.

Congratulations, Macomb County Medical Society!

* * *

USPHS—"Rudy Lang has resigned his commission in the U. S. Public Health Service and is now in

civilian clothing. We do not know what his plans are. Rudy resigned because the USPHS has recently allowed osteopaths to have commissions in their organization. Congratulations on your courageous stand, Rudy." —Bulletin Ingham County Medical Society, March, 1944.

* * *

Medical services are not "labor" and do not represent a preferred claim in a bankruptcy case. The general ruling on professional fees, according to the Referee in Bankruptcy, Detroit, is that such claims can only be allowed as general unsecured debts for the reason that usually the physician maintains a separate place of business and must be construed to be an independent contractor. For a claim to receive the preferred allowance of a wage debt, the claimant must have occupied the position of an employe of the bankrupt.

* * *

Thirteen out of fifty-three! Michigan placed two city and eleven county health departments, out of fifty-three health departments in the nation, on the National Health Honor Roll for 1944. The Michigan health units which were granted awards are as follows: Detroit City, Jackson City, Allegan County, Barry County, Calhoun County, Dickinson County, Eaton County, Ingham County, Mason County, Menominee County, Midland County, Saginaw County, and Van Buren County.

* * *

F. A. Brockenshire, M.D., Windsor, President of the Ontario Medical Association, 1943-44, and C. S. Sanborn, M.D., Windsor, President of the Ontario College of Physicians and Surgeons, 1943-44, were honored with a testimonial banquet by the Essex County Medical Society (Windsor, Ontario), at Beach Grove Golf Club, May 3. A number of Michigan doctors attended this event, lending it an international flavor. The official representative of the Michigan State Medical Society was A. S. Brunk, M.D., President-elect. He was accompanied by Secretary L. Fernald Foster, M.D. and Executive Secretary Wm. J. Burns.

* * *

Ingham County Medical Society's May Clinic a great success. The tenth annual Clinic of the Ingham County Medical Society was held in Lansing, May 4, with 189 attending. Talks were given by John W. Hirshfield, M.D., Detroit, Mandred W. Comfort, M.D., Rochester, Minnesota, Sidney Farber, M.D., Boston, Massachusetts, Franklin B. Beck, M.D., Indianapolis, Indiana, and H. Winnett Orr, M.D., Lincoln, Nebraska. H. H. Cummings, M.D. of Ann Arbor, immediate Past-President of the Michigan State Medical Society, presided at the dinner meeting. Present from the Michigan State Medical Society were President C. R. Keyport, M.D., Grayling, L. Fernald Foster, M.D., Bay City, Secretary, Wm. A. Hyland, M.D., Grand Rapids, Treasurer, V. M. Moore, M.D., Grand Rapids, Chairman of The Council, Philip A. Riley, M.D., Jackson, Councilor of Second District, Ray S. Morrish, M.D., Flint, Councilor of Sixth District, W. E. Barstow, M.D., St. Louis, Councilor of Eighth District, and O. D. Stryker, M.D., Fremont, Councilor of Eleventh District.

MSMS Broadcasts.—The medical broadcasts over Radio Station WJR sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Ann Arbor, Chairman), in coöperation with the University of Michigan, for June are presented at 11:30 p.m. every Thursday, as follows:

June 1—Paul H. Noth, M.D., Associate Professor of Medicine in the Wayne University College of Medicine: "You and Your Heart."

June 8—Henry Field, Jr., M.D., Professor of Internal Medicine in the University of Michigan Medical School: "Present Status of the Question of Vitamin Nutrition."

June 15—Leo H. Bartemeier, M.D., President of the Michigan Society of Neurology and Psychiatry: "Psychiatry and the War."

June 22—Frederick F. Yonkman, M.D., Professor of Pharmacology and Therapeutics in the Wayne University College of Medicine: "Those Drugs of Ours."

June 29—Clement A. Smith, M.D., Professor of Pediatrics in the Wayne University College of Medicine: "The Prevention and Control of Tuberculosis in Childhood."

* * *

FIVE PER CENT DECIDES ELECTIONS!

A mere four or five per cent in a constituency may determine whether a strong man or rubber stamp goes to Congress. Figure it out this way: In every district about 65 out of every 100 are registered voters. Of this sixty-five, about forty vote on Election Day. Of these forty, only sixteen vote in the primaries—which is an average of eight in either party. Of these eight, a candidate needs only five to win a primary. Thus, a minority group which knows what it wants and how to get it, may send a human rubber stamp to Congress although that minority may number less than 5 per cent of our population.—*Committee for Constitutional Government, Incorporated.*

* * *

GUEST ESSAYISTS AT 1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE

At the 79th Annual Session of the Michigan State Medical Society, to be held in Grand Rapids, September 27-28-29, 1944, the following guest speakers from outside of Michigan—among others—will be on the program:

E. C. Faust, M.D., New Orleans, La.
Geza De Takats, M.D., Chicago
Robert A. Moore, M.D., St. Louis
Tom D. Spies, M.D., Cincinnati
John W. Harris, M.D., Madison, Wisc.
Arthur W. Proetz, M.D., St. Louis
Max M. Zinninger, M.D., Cincinnati
A. D. Ruedemann, M.D., Cleveland
Joseph L. Baer, M.D., Chicago
E. A. Rovenstine, M.D., New York, N. Y.
Frank H. Krusen, M.D., Rochester, Minn.
Herman Hilleboe, M.D., Bethesda, Md.
Major Frank H. Mayfield, MC, Cincinnati—now stationed at Battle Creek, Mich.
C. A. Aldrich, M.D., Rochester, Minn.
Warfield T. Longcope, M.D., Baltimore
Lt. Col. Wm. C. Menninger, MC, Washington, D. C.
Sidney Farber, M.D., Boston
S. Wm. Becker, M.D., Chicago
Brigadier Jonathan C. Meakins, M.C., Montreal
Frederick H. Falls, M.D., Chicago
James L. Wilson, M.D., New York, N. Y.
Earl D. Osborne, M.D., Buffalo, N. Y.

RECENT TALKS

Fred R. Reed, M.D., Three Rivers, Chairman of the MSMS Public Relations Committee, addressed the Calhoun County Medical Society in Battle Creek on May 2: the St. Joseph County Medical Society in Sturgis on May 9; the Jackson County Medical Society in Jackson on May 16; and the Manistee County Medical Society in Manistee on May 18.

Robert H. Baker, M.D., Pontiac, a member of the MSMS Public Relations Committee, spoke to the Holly Board of Commerce on Holly on May 4, on "Federal Bureacracy."

L. Fernald Foster, M.D., Secretary, MSMS, addressed the Bay County Woman's Auxiliary, Bay City, on May 1, and the Calhoun County Medical Society in Battle Creek on May 2. Wm. J. Burns, Lansing, Executive Secretary, MSMS, addressed the Michigan Trudeau and the Michigan Tuberculosis Association in Grand Rapids on May 25. N. J. Walton, M.D., Quincy, addressed the Quincy Rotary Club on March 6 on "Political Medicine."

* * *

Chiropractic corps in Army Medical Department. Representative Tolan of California, recently presented another gem in the nature of a bill to the Congress (H.R. 4533), to establish a chiropratic corps in the medical department of the U. S. Army. The duties of the officers will in general be to provide chiropractic service to the Army in the same manner as "other professional corps provides specialized professional service." The Army Surgeon General will be authorized to appoint officers in the corps in such number as shall be in the ratio of one officer of the chiropractic corps to each 100 officers of the Medical Department, original appointments to be Second Lieutenant. The bill also contemplates the establishment of a chiropractic reserve corps.

* * *

Osteopaths as commissioned medical officers in the Navy. Admiral Ross T. McIntire, Chief of the Bureau of Medicine and Surgery of the Navy, in discussing a bill (H.R. 4559), introduced into the Congress to permit the commissioning of osteopaths as medical officers in the Navy, stated: "It is my understanding that within the past year, some of the better schools of osteopathy have modified their curricula to include preventive medicine, and chemotherapy. This improved their courses of instruction and eventually will result in better professional qualifications for their graduates; however, at this time the standard osteopathic education does not meet the requirements of colleges of medicine which give the degree of doctor of medicine to their graduates.

"In order that all personnel of the Navy, Marine Corps, and Coast Guard assigned to the Navy, may have available to them the highest type of professional service it is considered to be to the best interests of the Medical Department of the Navy that only those physicians and surgeons who have graduated from a class A medical school be accepted for appointment in the Medical Corps.

"In my testimony of last year before this committee, I pointed out that osteopathic graduates were not given unlimited licenses to practice medicine and surgery in all

States and Territories of the United States and I believe the Navy would be subject to severe criticism if it forceably subjected its service personnel to medical and surgical treatment from other than medical officers who are considered fully qualified in all aspects to administer this type of treatment. It is not practicable to accept into the Medical Corps of the Navy a group of physicians whose professional qualifications are restricted to a special type of treatment and who in many States, are not licensed to administer narcotics, and whose scope of the practice of medicine and surgery is limited."

The following quotation from "Management's Washington Letter," appearing in *Nation's Business* for April, 1944, official publication of the U. S. Chamber of Commerce, will be of interest. The Letter reads in part as follows: "Your Postwar Labor Relations program probably will include group medical insurance for workers and families—and an increased cost of doing business. Nation-wide study by Opinion Research Corp., shows only 8 per cent of population favors federal health insurance and care supported by increased Social Security pay roll deductions. But 39 per cent favor systematic prepayment of medical care on insurance principles under employer sponsorship. For whole nation, 63 per cent favor some plan 'to make it easier to pay doctor and hospital bills.' Every year 58 per cent of population see a doctor (not including dentist). But only 33 per cent are home in bed more than one day. Measured in family units, 59 per cent spend less than $50 yearly for doctors; 34 per cent spend over $50, and 7 per cent don't know total. On reasonableness of doctor bills 77 per cent of total population said not too high; while 21 per cent said 'too much.' (On hospital bills, 17 per cent said too much.) Today, 22 per cent of U. S. workers are covered by employer-supported medical plans at group-insurance rates ranging from 80c to $2 weekly payroll deductions, varying with number of dependents; and 41 per cent more say they would be interested in such a plan. Significance: approximately 80 per cent of U. S. population find prevailing medical system satisfactory and adequate; remaining 20 per cent feel family medical costs are burdensome."

* * *

The Huron County Medical Society entertained members of the Bay County Medical Society at Bad Axe on April 26. Professor Paul D. Bagwell, head of the Department of Speech of Michigan State College was speaker of the evening on the subject "Political Medicine."

* * *

Citizens, Attention! Physicians, as citizens, must become interested in the primaries of July 11, 1944, especially in candidates for the Michigan Legislature and particularly those who aspire to the State Senate. Doctors should carefully scrutinize the lists of candidates and take appropriate action. As citizens, it is your duty to help insure the nomination and election of the best possible talent for the State Legislature which body has the power to make and change the laws affecting public health and the practice of medicine.

* * *

Are you on this sucker list? "I would like to enter into an arrangement with you requiring your full time service away from your office. If you are available

and willing to leave town, I can offer you a minimum guarantee of $75.00 per week refracting patients who are recommended to you. Experience in refraction is not necessary. Office space is provided. This will be a permanent arrangement with an opportunity to earn more than $75.00 per week, and requires absolutely no selling on your part. If interested, kindly wire (charges collect) at once."

This "come on" postal card has been circulated among Michigan physicians periodically for several years. It indicates the manpower-turnover problem of an advertising optical house with headquarters in Chicago and branches in various cities of Michigan. Only the waste paper drive will be aided by this literature, so consign the postal card to the nearest trash basket.

* * *

Electrocardiography.—A full-time two weeks' intensive course is offered at Michael Reese Hospital, 29th and Ellis Avenue, Chicago 16, during the period beginning August 21. Fee for course and materials is $110.

* * *

The Michigan Society of Neurology and Psychiatry.—The fifth regular meeting of the current year of the Michigan Society of Neurology and Psychiatry was held in Detroit on April 27, under the presidency of Dr. Henry A. Luce, of Detroit. The program was as follows: Mr. Lee White, Director of Public Relations, *The Detroit News,* "What the Press Thinks of Psychiatrists"; Mr. William E. Dowling, Prosecuting Attorney of Wayne County, "What Psychiatrists Can Do to Aid Justice"; Hon. Joseph A. Gillis, Judge of Recorder's Court, Detroit, "Psychiatrists at the Bar of Justice"; The Rev. Hugh P. O'Neill, S.J., Faculty of the University of Detroit, "The Clergy Looks at Psychiatry."

Leo H. Bartemeier, M.D., of Detroit, was installed as president of the Society for the coming year, and Roy A. Morter, M.D., Director of the Kalamazoo State Hospital, Kalamazoo, Michigan, was named president-elect.

* * *

Executive Orders constitute another phase of the broad control of government exercised by the President in an unprecendented manner. President Roosevelt has issued 45 per cent of all executive orders *since and including the administration of President Lincoln.* He has issued twice as many as any other President in the history of our Republic and twice as many as the combined number of executive orders issued during both the Civil War and World War I. In some years his executive orders, which often have the effect of law, have even exceeded the number of laws passed by Congress in the same period. Since he took office in 1933, President Roosevelt has issued 3,707 executive orders as compared to the 4,553 laws enacted by Congress during the same period. These executive orders are in addition to the multitude of "administrative" orders issued by his bureau chiefs in the jig-saw puzzle of New Deal agencies.—*Fred L. Crawford, MC, 8th District, Michigan.*

* * *

Governor Kelly stated that the farm manpower situation will be eased this year by the importation of 15,000 to 16,000 workers of Mexican descent, several hun-

dred Jamaican laborers, and the use of prisoners of war. A first group of prisoners of war arrived this week at Hartford. They will receive 81 cents per day for their work, but employers will pay the Federal Government the current rate for labor. The difference will contribute to their maintenance.

* * *

The Tax Study Committee listened with favor to a suggestion for a constitutional change to produce a simple, fair and workable intangible tax law. Chairman Brake, State Treasurer, said no objections were voiced to a proposal to submit a constitutional amendment to clarify "uniform taxation." Senator George P. McCallum reported against any new attempt to enact a State income tax, pointing out that voters have rejected this levy four times.

* * *

Graduate program in venereal disease in Upper Peninsula.—This special program was held the week of May 23 in the cities of Sault Ste. Marie, Marquette, Houghton, Ironwood, and Powers, and marked the culmination of a program recommended by the MSMS Venereal Disease Control Committee last year. The course consisted of lectures by L. W. Shaffer, M.D., Detroit and N. W. Guthrie, M.D., Lansing, preceded by a consultation service for physicians.

* * *

The Michigan Pathological Society held its regular bi-monthly meeting on April 15, 1944, at St. Joseph's Mercy Hospital, Detroit. The scientific session was devoted to a seminar on "Tumors of the Ovary" and was conducted by Dr. Walter Schiller of Chicago. There were 57 members and guests present.

An agreement was adopted with Michigan Medical Service and Michigan Hospital Service which provides that pathological services to subscribers for prepaid hospitalization or medical care be furnished under a contract written by Michigan Medical Service.

* * *

The Ionia-Montcalm Medical Society recently issued a Bulletin dedicated to "Our Members in the Service." This eight-page booklet, prepared by M. A. Hoffs, M.D., of Lake Odessa, is a chatty résumé of what's going on in Ionia-Montcalm Counties, just where the various military members are located and what they are doing, and many personal items which make the *Bulletin* the equivalent of a friendly and personalized letter to each physician in service who received it.

* * *

Thirty million of the Nation's 50,000,000 income taxpayers will enjoy simplified methods of making their return as a result of approval given by the House Ways and Means Committee to legislation designed to make it easier to compute and file the tax forms. Under the proposed system, the present method of withholding taxes from wages and salaries will be revised to deduct the full tax liability for persons earning up to $5,000.

The plan, which would not become effective until January 1, 1945, would abolish the Victory tax, establish a new normal rate of 3 per cent on all persons making more than $555 a year; and start exemptions from a base of $500, plus 10 per cent of income, with similar adjustments for the surtax. Surtax rates would begin at 20 per cent instead of the present 13 per cent.

The United States Children's Bureau announces the appointment of the following new members of the Chil-

dren's Bureau Advisory Committee on Maternal and Child Health Services. These members were appointed in response to the resolution adopted by the Advisory Committee on Oct. 21, 1943, requesting that the committee be enlarged by the appointment of at least five physicians actively engaged in the private practice of medicine: Sterling H. Ashmun, M.D., Dayton, Ohio; Harvey F. Garrison, M.D., Jackson, Miss.; Eleanor Harvey, M.D., Newport News, Va.; John Preston, M.D., Tryon, N. C.; S. A. Thompson, M.D., Camden, Ark.; George D. Cannon, M.D., New York.

In addition, the following members of the Children's Bureau Commission on Children in Wartime, have been appointed ex officio on the Advisory Committee on Maternal and Child Health Services: Frederick H. Allen, M.D., Philadelphia; Leona Baumgarten, M.D., New York; Reginald M. Atwater, M.D., New York; Franklin P. Gengenbach, M.D., Denver; Joseph S. Wall, M.D., Washington, D. C.

* * *

WORKING IN SILENCE

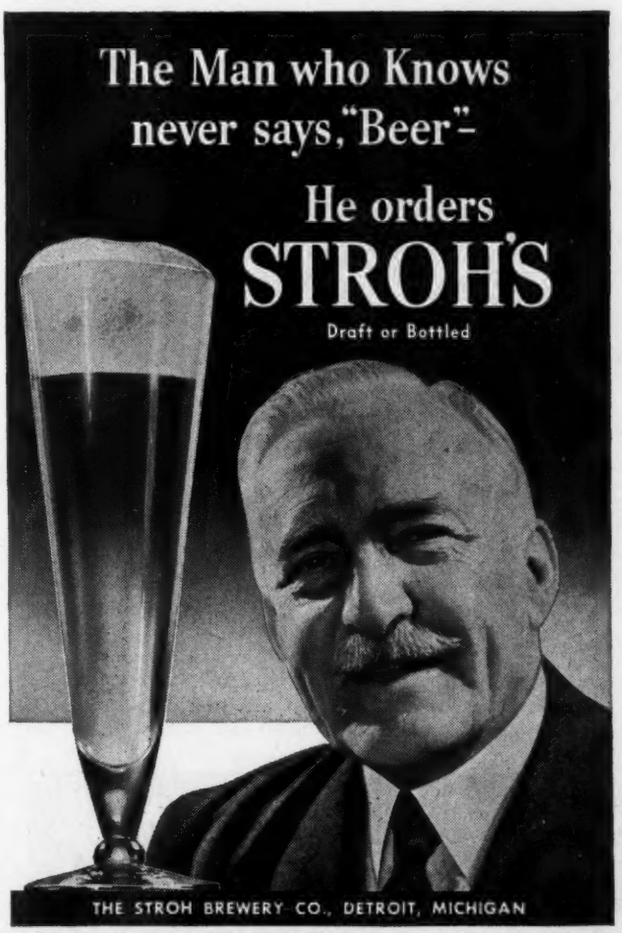
"No headlines herald the progress of the medical profession in its efforts to distribute adequate medical care to every section of the country. As usual it serves in silence.

"The *American Medical Journal* points out that there are two objectives which the doctors seek: First, the best distribution of available resources of medical personnel and the health protection of the largest number of people; second, the doing of this in such a way as to preserve the rights and advantages that inhere in local self-government.

"Moves are afoot to ease medical licensing restrictions between states. This has been a stumbling block in the way of physicians moving from state to state in accordance with the needs of areas critically short of doctors. Another important step was the recent formulation of plans whereby the United States Public Health Service could help meet the need for medical services in critical areas. The doctors are striving, irrespective of thinning ranks, to maintain one physiciaan to 1,500 people. In some cases the average may be less, but even so, Americans will still be the best cared for people in the world.

"In Germany, doctors are practically nonexistent for civilians. Russia is no better. This fact should be noted carefully. Both the Russian and German medical systems were prepared for war, under "planned" dictatorial economics, yet the test of global war found them both wanting as compared to the progressive American medical system, built on the foundation of initiative, service and sacrifice of our independent medical profession."—Editorial in *Sandusky Republican-Tribune* (Michigan), April 21, 1944.

Selection of nursing as your vocation is a serious responsibility. Remember the parable of the talents. You have those qualities we feel are important for nursing: youth, health, personality, preparation and intellect. Make use of these gifts together with what our hospital has to offer you. But remember also to "Give and it shall be given unto you."—AUGUSTA DUTTON, *Harper Hospital Bulletin,* April, 1944.



THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

ESSENTIALS OF DERMATOLOGY. By Norman Tobias, M.D., Senior Instructor in Dermatology, St. Louis University; Assistant Dermatologist Firmin Desloge and St. Mary's Hospitals; Fellow American Academy of Dermatology and Syphilology; Diplomate American Board of Dermatology and Syphilology. Second Edition. Philadelphia: J. R. Lippincott Company, 1944. Price, $4.75.

This volume is an attempt to place a handy manual of dermatology in the hands of the busy practitioner and the student, so in the haste of the times it will not be necessary to study the larger complete texts. The descriptions are concise and without long histological comments. For practical use the volume is ideal, leaving intensive study to the specialist with his tomes and treatises. This volume contains many well executed photographs, and sufficient discussion of the diseases described so that a diagnosis can be made, and the treatment is fully outlined. Inside the front cover are two pages on the use of the sulphonamides in dermatology. Inside the back cover is a long list of normal values.

A TEXTBOOK OF PATHOLOGY. Edited by E. T. Bell, M.D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn. Fifth Edition, Enlarged and Thoroughly Revised. Illustrated with 448 engravings and four colored plates. Philadelphia: Lea & Febiger, 1944. Price, $9.50.

Bell's Pathology makes its fifth appearance at a time when shock, explosion injuries and vitamin deficiencies are foremost in our minds. These subjects are especially well handled in this volume, which follows the high standard of its predecessors. The text material is condensed to small space and for easy assimilation. This is a textbook of pathology that leads gradually and logically into the practice of medicine. It is a well-adapted text for the busy practitioner as well as the student.

CLINICAL LECTURES ON GALL BLADDER. By Samuel Weiss, M.D., F.A.C.S., 496 pages. Chicago: The Year Book Publishers, Inc., 1944. Price, $8.50.

This is a new book which should find immediate acceptance and enthusiastic approval by medical students in particular and the general profession at large. It fills a gap between the brief outlines designed as guides to further reading and the more massive volumes on this subject which are too time consuming for careful study.

Well written and adequately illustrated, this book provides easy and interesting reading of a complicated and comprehensive subject. The internist and surgeon alike will benefit from cover to cover reading of this important phase of their practice. The anatomy and physiology of the biliary system is well presented and emphasis is placed on the history and examination which lead to exact diagnosis.

Acute and chronic cholecystitis, pseudocholecystitis, cholelithiasis and their complications are dealt with in proper detail. The interesting question of medical or surgical management of each disease is presented and the indications for surgery outlined. Gall-bladder disease

is discussed in its relation to arthritis, cardiac disease and other systemic infections acute and chronic. Benign and malignant tumors are reviewed. The etiology and clinical manifestations of jaundice, liver function tests, hypoprothrombinemia, and preoperative and postoperative medical care are presented in the light of recent research and clinical work, stressing new therapeutic measures.

This is not simply a reference textbook, but rather a very practical volume to study over and over again.

SYNOPSIS OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY, For Students and Practitioners of Medicine. By Forrest Ramon Davison, B.S., M.Sc., Ph.D., M.B. Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Medical Department. The Upjohn Co., Kalamazoo. Third Edition. St Louis: The C. V. Mosby Company, 1944.

This is a condensed materia medica with practically every drug described in its proper classification, giving the effects, action, and prescriptions for the use. It includes a chapter on the sulfonamides, giving their structural formulæ, and uses. The vitamins and biologicals are included, with their structural formulæ if worked out, and administration. A very handy book.

QUARTERLY REVIEW OF SURGERY. Vol. 1, No. 2, February, 1944. By Henry N. Harkins, M.D., Editor-in-Chief. Washington, D. C.: Quarterly Review of Surgery, 1944.

This volume contains short and clear reviews of articles that have been recently published on surgery of the Thorax, Abdomen, Kidney, Blood Vessels and Lymphatics, Bones and Joints, Thyroid, Traumatic and Industrial Surgery, and general—in all, about ninety-six reviews by twenty-one reviewers. On the editorial board are the following from Michigan: Alexander W. Blain, Frederick A. Coller, Roy D. McClure. The Editor was recently at Henry Ford Hospital, Detroit.

RORSCHACH'S TEST. I. Basic Process. By Samuel J. Beck, Ph.D., Head of Psychology Laboratory, Department of Neuropsychiatry, Michael Reese Hospital, Chicago. Associate Professor of Psychology, Northwestern University. Foreword by William L. Valentine, Ph.D., Head of Department of Psychology, Northwestern University. New York: Grune & Stratton, 1944. Price, $3.50.

This is Doctor Beck's second volume about the Rorschach test, and is written to demonstrate the processes used to evaluate the test responses. This gives a manual of usage so that the reults of tests by different investigators can be compared. There is some difference of opinion as to the value of the method. These are discussed briefly, and innumerable responses are recorded. The text is interesting to the initiated, but unintelligible to the average practitioner. Its value to the worker in psychology and psychiatry could be far reaching.

MANUAL OF THE DISEASES OF THE EYE. For Students and General Practitioners. By Charles H. May, M.D., Consulting Ophthalmologist to Bellevue, Mt. Sinai and French Hospitals, etc. Eighteenth Edition, revised with the assistance of Charles A. Perera, M.D., Associate in Ophthalmology, College of Physicians and Surgeons, Medical Department of Columbia University. With 387 Illustrations. Baltimore: William Wood and Company, 1943. Price, $4.00.

Dr. May's little textbook on the eye is up to the same high standard of its many years and editions. Many of the illustrations are new, all are good, and

instructive. This volume is of especial value in view of the many state compensation laws fixing the value of loss of industrial vision, and methods of determining compensation. These facts are difficult to refer to on the spur of the moment or when a court case impends, but in this volume is the abstract of the AMA committee report. This one feature is well worth the cost of the book.

A NEW TEST FOR SYPHILIS. By Anson Lee Brown, A.B., M.D., Dr. Brown's Clinical Laboratory, Columbus, Ohio.

CLINICS. Vol. 2, No. 5, February, 1944. Philadelphia: J. B. Lippincott Company.

A Symposium on War Medicine is included in this issue, the teaching panels presented at the 51st Annual Meeting of the Association of Military Surgeons of the United States, Philadelphia, October, 1943. These articles are well worth reading.

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POLITICAL MEDICINE

RESOLUTION COMMITTEE MEETS

A Resolutions Committee consisting of members and representatives of the state medical societies of Colorado, Idaho, Indiana, Nebraska, Oregon, South Dakota, Washington, Wisconsin, and Wyoming met in Denver, Colorado, April 28 and 29, 1944. The results of their deliberations are produced herewith:

The enactment by Congress of legislation providing funds to pay the cost of securing adequate maternity and pediatric attentions for the wives and children of enlisted men of the lowest four grades is an extension, as a wartime measure, of principles with which we, as practicing physicians, are in entire accord. It is our earnest desire to aid in every possible way the application of these services with fairness to the hospitals and to physicians who furnish the actual care, to the Congress of the people of the United States, which provides the necessary funds, and especially to the wives and children who need and are entitled to receive these benefits.

We, therefore, members and representatives of the State Medical Societies of Colorado, Idaho, Indiana, Nebraska, Oregon, South Dakota, Washington, Wisconsin, and Wyoming, in session in Denver, Colorado, Friday and Saturday, April 28 and 29, 1944, present for consideration the following resolutions as the expression of our deliberations:

RESOLVED, That further conferences may be called by the permanent chairman at his discretion for the purpose of discussion and solution of various obstetric and pediatric problems which arise under this Act of Congress.

RESOLVED, That the various interested state medical societies appoint a representative who can be called in to similar conferences in the future.

We, the members and representatives of the state medical societies of Colorado, Idaho, Indiana, Nebraska, Oregon, South Dakota, Washington, Wisconsin, and Wyoming, therefore present to our respective societies the following resolutions for consideration:

WHEREAS, a growing feeling exists throughout the country that the present E.M.I.C. program is unsatisfactory because of the autocratic and dictatorial manner in which the Children's Bureau had administered the program, thus destroying the confidence which physicians should have in the Bureau; and

WHEREAS, The Bureau has inflicted its own plans on the State Boards of Health and the practicing physicians and hospitals, completely ignored the advice and plans offered by the State Committees, and have thereby enormously increased the administrative cost to each state and disrupted the usual functions of the State agencies, and furthermore it has placed the soldiers' wives in the same category with indigent patients; and

WHEREAS, Ample and efficient facilities for the disbursement of such funds as Congress may allocate already exist in the Army Office of Dependency Benefits in Newark, New Jersey, and Bureau of Navy Personnel, Navy Department, Washington; and

WHEREAS, we believe that the program can be more economically, efficiently, and satisfactorily administered by direct allotments through these agencies.

We, therefore, suggest that upon receipt of an affidavit signed by any licensed physician of the state in which he resides, certifying an enlisted man's wife is pregnant, that these same agencies shall, upon termination of the case, forward to the wife such funds as Congress shall deem necessary to cover hospital, medical, and nursing care.

We further suggest that the same procedure be followed in furnishing care to the infants of enlisted men of the grades specified during the first year of life.

RESOLVED, that inasmuch as the principle of allotment payments has been approved by many state medical societies and the American Medical Association that Congress be urged to take such steps as may be necessary to remove this program from the direct supervision of the Children's Bureau and place it on an allotment basis, thus releasing the State Boards of Health to carry on their regular public health work and removing a regulatory board now placed between the patient and the doctor.

RESOLVED, That each state take definite action in conjunction with all other states in accord with these resolutions, to acquaint the congressional representatives of these states with the full intent of these resolutions; and be it further

RESOLVED, That copies of these resolutions be sent:

(1) To the secretaries of the state medical societies of the United States.

(2) To the American Medical Association (Olin West).

(3) To the physician members of Congress.

(Upon motion duly made, seconded and carried the above resolution was adopted.)

BRITAIN'S NEW HEALTH PLAN

London, May 13, 1944—Britain may be on the brink of one of the most revolutionary social reforms in her history, the institution of a national health service. The plan has been presented to Parliament in a White Paper by the Ministry of Health, which attempts to combine the most progressive principles of state medicine with the best elements of the present regime. It has three main objectives:

"1. Free treatment for every need, from minor ailments to major operations.

"2. To provide a network of the most up-to-date medical services and equipment, in which hospitals, the family doctor, dentists, nurses, and opticians would be included; the country would be split into areas, each of which, having a nucleus of all these services, would be medically self-sufficient.

"3. To encourage a new approach to health, which would hold that those who were averagely healthy

(Continued on Page 536)

BRITAIN'S NEW HEALTH PLAN

(Continued from Page 534)

should be helped to make themselves even healthier, and that at least as much attention should be paid to the prevention of disease as to its cure."

There would be no compulsion for patient or doctor. But:

"The new service will be there for everyone who wants it—and would indeed be so designed that it would be looked upon as the normal method by which people get all the advice and help which they want—but if anyone prefers not to use it, or likes to make private arrangements outside the service, he will be at liberty to do so."

That is, if under this plan there are any left who can carry on under the handicap. And the bureaucrats in Britain are also shrewd: "The Family Doctor . . . might, indeed, be better off for he would be paid regularly by the state . . . He would also have a less exhausting life, for the proposed health center system insures that the doctor who works hard all day does not have to cope with emergency calls at night." *This White Paper seems to be a very definite straw in the wind.*

TOO MUCH SICKNESS INSURANCE, NOT ENOUGH HEALTH INSURANCE

The terms "sickness insurance" and "health insurance" connote two quite different things. Sickness insurance concerns itself with facilitating the recovery of people from sickness, once it has overtaken them. Health insurance concerns itself with minimizing the hazards that are likely to make them sick. On the theory that the more effective health insurance is made, the less will be the costs for sickness insurance, it would seem only logical that Canada should be planning to spend more and more on preventive measures that will be permanent in their beneficial effect, so that she may look forward to having to spend less and less on medical services that merely put a temporary stop to troubles that need not have happened.—From *Health Insurance for Canada* by Research Bureau, Canadian Pharmaceutical Manufacturers' Association.

NEW TAXES

Business overhead increased appreciably when new federal excise taxes became effective.

Long-distance phone tax hiked from 20 to 25 per cent; telegraph tax upped from 15 to 25 per cent; local phone tax up from 10 to 15 per cent; railroad tickets, from 10 to 15 per cent.

Admission tax doubled.

Local postage increased from 2 cents to 3 cents per ounce; air mail from 6 cents to 8 cents per ounce; mail insurance and C.O.D. fees doubled; registered mail fees upped one-third.

Retail toilet preparations and luggage doubled from 10 to 20 per cent.

Club dues tax advanced from 11 to 20 per cent; electric light bulbs, 5 to 20 per cent.

Social Security taxes continued at 1 per cent each for employe and employer through 1944.

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VETERANS' REHABILITATION

The rehabilitation of veterans is a specific responsibility of the Army, Navy and Veterans Administration, so assigned by law. Briefly, intensive treatment in military hospitals determines whether disabilities are recoverable and, hence, suitable to eventual return to duty. Serious handicaps receive special attention in designated hospitals where social adjustment and training go hand in hand with medical care. These patients when sufficiently recovered are discharged from the Army or Navy. Then the Veterans Administration provides vocational training and employment, provided the disability is service connected, that the person is honorably discharged and that rehabilitation is needed to overcome the handicap.

The expanding vocational rehabilitation program of the Federal Security Agency makes it doubly certain that private physicians will be keenly conscious of reconstruction and placement of the handicapped in employment. Under this program federal aid is provided to enable state boards of vocational education and state agencies for the blind to furnish disabled persons with all services necessary to render them employable or more advantageously employable. These services include medical and surgical care, hospitalization, physical and occupational therapy, prosthetic appliances, vocational counseling and training, maintenance during training, occupational tools and equipment, and placement in employment. Except for certain groups of war-disabled civilians and federal employees injured in line of duty, persons receiving physical restoration services or maintenance grants must be in financial need.—JAMA, May 27, 1944.

REPORT OF CIVILIAN EYE, EAR, NOSE, AND THROAT SPECIALIST WORK ON INDUCTION BOARD, U. S. ARMY, DETROIT, MICHIGAN

The committee was formed in December, 1940, and the work was started in January, 1941. The examinations were done at the Light Guard Armory with two men working each morning, starting at 7:30 and usually finishing before noon. When less than 100 men were to be examined only one man was called. The original group consisted of Drs. H. U. Mair, Harvey E. Dowling, Fred A. Lauppe, R. E. Anslow, W. S. Summers, Arthur S. Hale, John M. Carter, A. P. Wilkinson, James T. O'Hora and William S. Gonne. Before the year was over, Drs. T. Y. Watson, J. M. Sutherland, A. O. Brown, A. E. Vossler, L. Rubright, D. A. Cohoe, J. B. Morton and T. P. Clifford were added to the list of examiners.

Early in 1942 the committee was moved to the examining station on West Fort Street. Due to the increase in numbers examined many more doctors were called upon to serve, and two shifts were instigated. These two groups worked from 8:00 A.M. to 12:00 and 12:00 to 4:00 P.M. Again in 1943 the committee was moved to a new station at McDougall and East Jefferson Avenue. Still more examiners were required and the numbers examined each day were increased considerably. Now, in 1944, the name of the station is changed from an Induction Center to that of an Examination Center and it will be a very busy place due to reclassification and the fact that the physical examinations by pre-induction locations have been discontinued. There are now three shifts of examiners daily and the inductees who pass the physical examination are placed in a pool of either the Army, Navy or Marine Corps and are subject to call after three weeks.

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Littlejohn, William.....Bridgeman
Pritchard, H. M.....Niles
Schairer, William.....Coloma

Cass County

Zwergel, Edward H.....Cassopolis

Ingham County

Haynes, H. B.....Lansing
Ponton, Joseph C.....Mason
Seger, Fred L.....Lansing

Lenawee County

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Colbath, William E.....Fairfield
Hambly, S. B.....Onsted
Loveland, H. H.....Tecumseh
Raabe, E. C.....Morenci
Tubbs, R. V.....Blissfield

Marquette-Alger County

Robbins, N. J.....Negaunee

Mason County

Martin, W. S.....Ludington

Oakland County

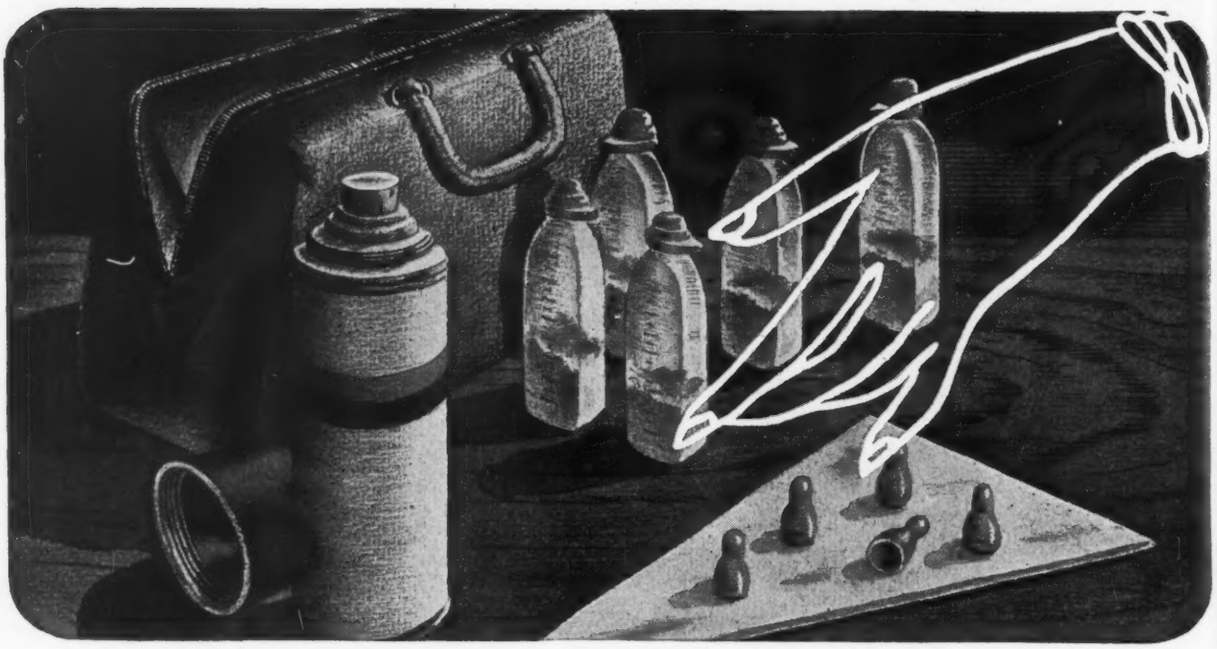
Cottrell, Martha S.....Novi
Grate, L.....Pontiac
Mehas, C. P.....Pontiac
Neafie, Charles A.....Pontiac
Sibley, Harry A.....Pontiac

Saginaw County

Ling, E. M.....Hemlock
Mayne, Harold.....Saginaw

Wexford-Kalkaska-Missaukee Counties

Brooks, George M.....Tustin
Masselink, H. J.....McBain



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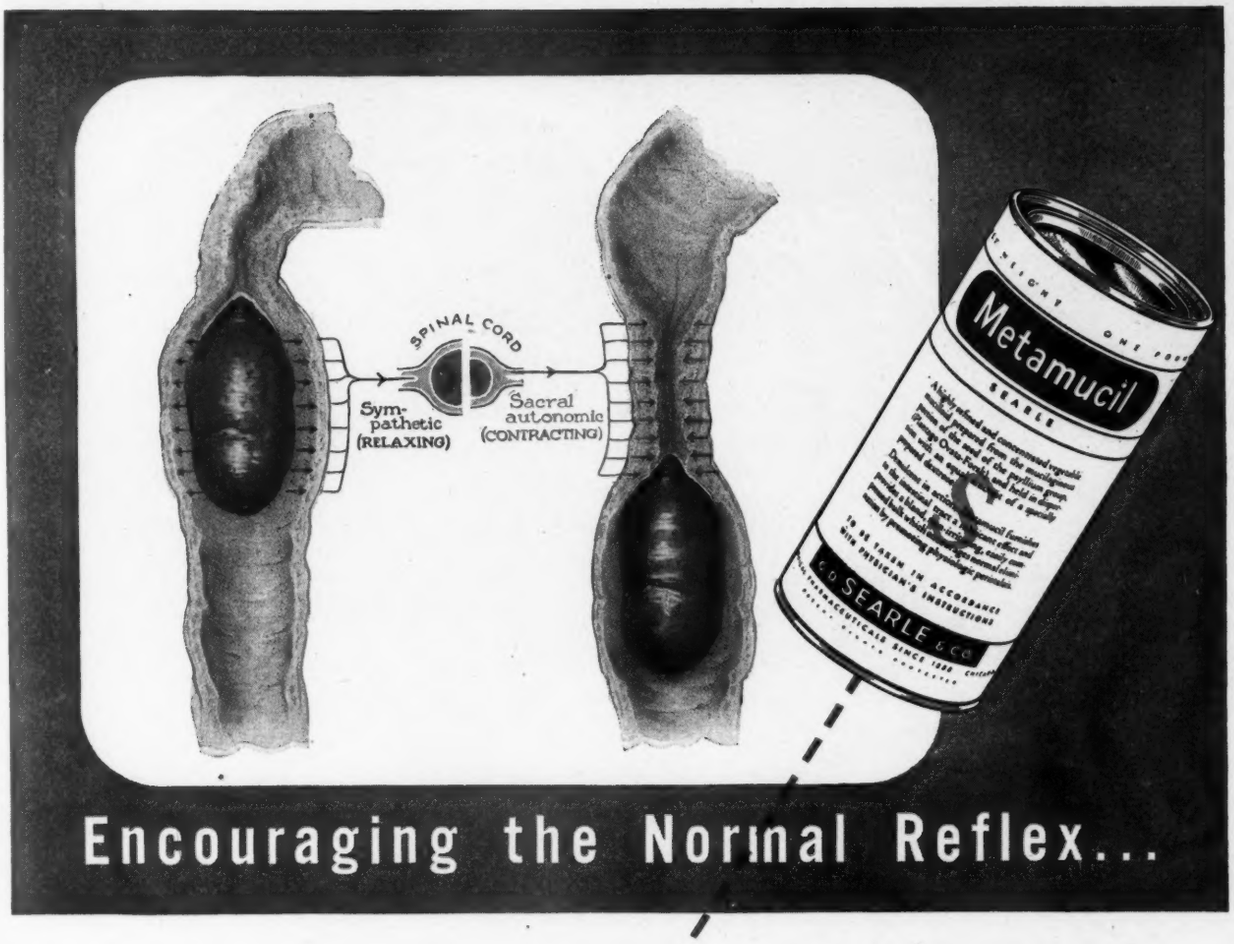

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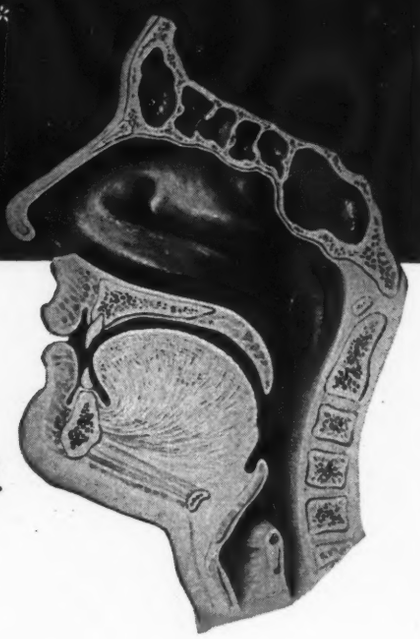

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